



No Wrong Door

Creating a Collaborative Rural
Response for Women with Abuse,
Mental Health and Addictions Issues

Final Report

Rural Strategies for Women with Abuse, Mental Health, and Addiction Issues Project

A Project of the Grey Bruce Violence Prevention
Coordinating Committee

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July 2008

::: Acknowledgments :::

This research and community development project was made possible through the generosity and courage of women in Grey and Bruce who came forward and spoke of their experiences with community services and their recommendations for change. We thank these patient and resilient women who brought such insight, quiet conviction, and determination to focus groups, interviews and community workshops. They welcomed an opportunity to speak about the reality of their struggles and successes with concurrent issues and with community services. They gave the researchers and service providers in Grey and Bruce a glimpse of the complexity they face every day, as they shared their experiences and stories of living with abuse, mental health and addiction issues. They did not shy away from frank and constructive critique, but they also offered a wealth of information about what they need, what helps, and how services could be organized differently to support women with concurrent issues.

We would like to thank the women and service providers who attended two community workshops to develop community strategies, bringing the knowledge of lived experience forward to inform action for a more integrated and coordinated community response for women and their children. We are indebted them and to the many service providers who took time from busy work schedules to participate in the service provider survey.

The members of the project advisory committee played a central role in all aspects of the project. They assisted in the organization of the focus groups and the dissemination of the service provider survey, reviewed reports, and attended community workshops. Thank you to all the members, and special thanks to Cheryl Bruce for her extensive work and advice for the development of community strategies, and to Melissa Weber for her advice at the beginning of the project.

The project consultants appreciated the tremendous support they received from the management and staff at Bruce Shoreline Counselling, CMHA Grey Bruce, The Women's Centre (Grey & Bruce), Women's House Serving Bruce and Grey, Grey Bruce Health Services (GBHS) Mental Health Services and GBHS Withdrawal Management Services for the organization of focus groups and interviews with women. These organizations provided space, staff support and refreshments that all contributed to a warm and welcoming environment for women.

Thank you to Julia Ostertag for the Literature Review and for updating it in July 2008, and to Sandy Stockman, Donna Beatty, Jim Catton and Caroline Tycholiz who provided encouragement and support to get the project started.

The support of the members of the Grey Bruce Violence Prevention Coordinating Committee, and our sponsoring agency, the Children's Aid Society of Owen Sound and the County of Grey, and Suzanne Mannerow, our administrative point person at the CAS, is sincerely appreciated. Finally, thank you to May Tettero, project consultant and Colleen Purdon, project manager and consultant, and to the Victim Services Secretariat of the Ontario Ministry of the Attorney General for project funding.

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::: Executive Summary :::

Victims of woman abuse who also struggle with mental health and addiction issues have complex needs that span health, justice, social service, violence against women, child welfare and First Nations services. The community services that women need are largely organized within distinct sectors that are guided by specific mandates, funding parameters, philosophies and treatment approaches. In rural communities such as Bruce and Grey Counties, women with concurrent issues face additional barriers to service because of isolation, poverty, the lack of transportation, the lack of affordable housing and childcare, limited services for Aboriginal people, and a general lack of women -specific services. Women in Grey and Bruce Counties who are dealing with concurrent abuse, mental health and addiction issues need an approach to service delivery that integrates and coordinates services and sectors and makes the best use of limited resources. The service response needs to recognize and respond to the complexities and barriers facing vulnerable women with multiple issues.

This report recommends a 'No Wrong Door' community approach to service delivery for women dealing with abuse, mental health and addiction issues. It captures the experiences, knowledge, recommendations and visions of women who use community services, and the men and women who provide them. At the end of a one year research and community development process the project participants called for an integrated and trauma informed approach to service delivery across the mental health, addictions, violence against women, justice, child welfare, and health and social service systems. A 'No Wrong Door' approach will ensure that every service door is a place where women with concurrent issues can find information, support, healing, and help.

The project was carried out by the Grey Bruce Violence Prevention Coordinating Committee (GBVPCC), a multi agency community committee dedicated to ending abuse and violence in all its forms in Grey and Bruce. The Children's Aid Society of Owen Sound and the County of Grey was the sponsoring agency for the project, with funding from the Victim Services Secretariat of the Ontario Ministry of the Attorney General. A Project Advisory Committee, with representation from mental health, addictions, VAW, First Nations services, Probation and women who used services guided all aspects of the project, and took an active role in the development of data collection tools and processes, development of strategies and action plans and a review of the final report

In August 2007 the GBVPCC launched the Rural Strategies for Women with Abuse, Mental Health and Addiction Issues project with the following goal:

To identify community strategies to improve intersector service coordination and to address service capacity issues and gaps in service for victims of woman abuse (domestic violence, sexual abuse) with mental health and/or addiction issues.

The Objectives of the project were:

1. To identify gaps in service for women with abuse, mental health and/or abuse issues
2. To hear from women how to better meet their service needs.
3. To develop community strategies to improve service delivery through coordination and training.
4. To develop community strategies to address service gaps that compromise the health and safety of women with multiple needs.

A Participatory Action Research process was used to engage women who used services because of concurrent issues, and service providers in information gathering and the development of recommendations and community strategies.

The initial research phase of the project included a review of Literature, focus groups and interviews with 36 women who used community services because of mental health, addiction and abuse issues, and an electronic survey completed by 71 service providers in Grey and Bruce. The data was analysed and was used to create a Gap Analysis and a summary report on findings and key themes. Two community workshops were held with providers and women who used services to develop a Community Strategies and Priorities for Action.

The research and community workshops with women and service providers confirmed a need for change in the way services and supports are provided.

Findings from the Research

The findings from the research are discussed under four headings: Issue Identification, Getting Help, System and Service Coordination, and The Need for Change. A summary of these findings is as follows:

- Women experience a range of complex, interrelated issues
- All (100%) of the women experienced some form of abuse during childhood, in their teen years, and /or adult years, and many women experienced multiple forms of abuse, beginning in childhood and continuing to the present. Sexual abuse (as a child or adult) and emotional abuse by a partner were both experienced by 88% of women in this study. Most women (88%) experienced mental health issues

(depression, anxiety) and almost two thirds (64%) experienced addictions in their family of origin.

- “One issue follows another”
- Women reported a similar number of mental health, addiction and abuse/trauma issues, regardless of which sector/agency they were involved with when the focus group took place. This indicates that the range and types of issues that women are dealing with are rather similar, regardless of the point of service where women find themselves. The maps suggest the experience of abuse, precedes all other issues.
- Identifying issues can be difficult for women
- Women first identified issues as a result of a crisis.
- Women didn’t get the information they needed to identify their issues, especially from family doctors.
- Abuse issues are difficult for women to identify.
- The abusive partners in women’s lives make it difficult to identify the issues.
- There are barriers to getting help.
- Needed services are not available
- Sectors and services frame what is ‘wrong’ with women
- There are strengths and weaknesses in the service response.
- ‘The system is a maze’ describes how women experience sector and service coordination

Key Service Gaps and Capacity Issues

Providers and consumers identified the following gaps and capacity issues:

- Early interventions and prevention strategies
- Access to family physicians, psychiatrists and psychologists
- A recovery home for women in Grey and Bruce
- Information and education for women
- A voice for women in treatment and service planning/delivery
- Trauma informed counselling services for women with mental health, addiction and abuse issues
- Counselling and programs for the children of women with concurrent issues.
- Long term support for women with concurrent issues
- Community safe places for women with concurrent issues

- Better service access (evenings/ weekend hours, transportation, childcare, wait lists, poverty related barriers)
- A common understanding and approach to women across the service system
- Common screening and assessment processes across the service system
- Case management and a case worker who stays with the woman as she moves across services
- Inclusion of all providers who are part of the service system (currently doctors, private counsellors, and others are not linked within the system)
- Coordinated strategies to address stigma around mental health, addiction and abuse issues in the community

Seven Areas for Change Identified by Women

1. *Identify abuse issues sooner.* Provide more information for women about abuse, the impact of abuse and its connection to mental health and addiction issues. Train providers to identify past and current abuse, the impact of current and past abuse on a woman's help seeking behaviours, safety issues for abused women (including how abusers continue to control women), and the connection between past and current abuse and her mental health and addiction issues. Provide earlier interventions to address childhood and current abuse issues (proactive instead of reactive response).
2. *Educate doctors and psychiatrists* about abuse, the impact of abuse on mental health, community services and supports, proper use of medications with women with current and/or past abuse/trauma issues, the doctor's role in service coordination.
3. Provide services that equip women with tools, skills, options, where she can gain control of her life.
4. Coordinate community services and develop an integrated service delivery model for women with abuse, mental health and addiction issues.
5. *Change community attitudes that stigmatize* and isolate women with abuse, mental health and addiction issues. Provide information to professionals, families, and friends on how to support women and children in a positive way.
6. Make *changes in the legal system* (criminal and family court) so abusers cannot manipulate, control and intimidate women with mental health and addiction issues.

7. *Improve services and supports for children* who witness abuse and parenting supports for women dealing with abuse, mental health and addiction issues.

Eight Areas for Change Identified by Service Providers

1. *Intersector training* on: trauma and the link to mental health and addictions, effective screening, assessment, treatment and support approaches, working together, integrated service delivery.
2. Develop *formal sector collaboration, partnerships and strategies* to address service gaps and barriers to service
3. Create *networking opportunities* to share information and expertise
4. Implement *case coordination* across sectors and services
5. Develop *protocol agreements* to support strong relationships
6. Implement formal sector collaboration to address service barriers
7. Include Aboriginal healing approaches and best practices
8. Develop *integrated delivery of service* (for example services work together to provide groups, services co-located)

Seven Guiding Principles for Positive Change

The 5-year WCDV (Women, Co-Occurring Disorders & Violence) studyⁱ in the United States provides compelling information about the interrelation between violence, trauma, and co-occurring mental health and substance abuse disorders. The study provides recommendations for “trauma-integrated services,” and led to the development of guiding principles for positive change. These principles are relevant for Grey and Bruce and can be used to support community strategies for change:

- Service providers must better *recognize the presence of trauma*, past and present, as a central concern in a woman's life.
- *Women should be encouraged to play an active role in goal-setting* for their services plan and to develop their capacity for self-directed healing, and that they will benefit from a better understanding of how to do so, from the onset.
- *Symptoms are adaptations to traumatic events*—a means by which survivors seek to manage the negative emotional and psychological experiences precipitated by trauma using whatever “self-soothing” means that are available to them at the time.
- *Providers must understand how trauma is triggered* and how to help women create strength-based safe “spaces” in which women can manage their symptoms.

- Providers should be mindful of the ways in which their own practices and policies might put women in danger, physically and emotionally, or bring about re-traumatization.
- There must be a more widespread and comprehensive recognition that violence and trauma significantly impact a person's belief system, self-perception, and relationship with others.
- Providers need to *meet women where they "are" mentally and emotionally*, with careful readiness assessments, pacing, and a long-term perspective.

The Community Workshops identified six priority areas for change and action items for each priority area:

1. Women of Experience Steer the Process of Change

Women who use services are the reason for the service and must have a primary role in community coordination and integration work to make services more helpful and effective. Service sectors and providers must carefully think about the important role of women and make legitimate space for women of experience to exercise their role.

Recommendations for actions include:

- Provide women with information and opportunities for engagement
- Clarify values within organizations to support women's involvement
- Build knowledge and leadership with women
- Engage women and providers in dialogue for change
- Evaluate where we are and where we need to go.

2. Intersector Collaboration

Intersector collaboration is needed to bridge sectors that have diverse mandates, philosophies and funding parameters. System and service collaboration is needed and will require some changes in the way sectors and providers work.

Action Items for Systems Collaboration include:

- A working collaboration between mental health, addictions, VAW, health, justice and child welfare is necessary and will require support from sector planning bodies (LHIN, provincial associations, provincial funders).
- Shared funding to support specific collaborative activities such as transportation, volunteer supports, information and education activities, joint training initiatives.

- Shared space that would support an integrated service response in one location
- Education and engagement of all sectors, including health services and family practitioners.

Action Items for Service Collaboration include:

- An intersector case management approach that supports women over many years of service, and that is based on a client centred and trauma informed approach.

3. Formal Protocols

We need formal protocols between sectors and services that detail how service coordination and intersector collaboration happens. Women of experience have an important role to play in the development of these protocols. There is currently a broad intersector protocol in place that supports a community response to abuse that could be used as a starting point.

The formal protocol should include:

- Common mission and goals
- Partnering agreements between services
- Training – mandatory training for all sectors and training plans
- Collaboration agreements
- Service access agreements

Some potential barriers that will need to be addressed in protocol work include:

- Legislation and mandates governing sector work
- Time and funding required for protocol development, implementation and training
- Motivation by key sectors to formally enter into agreements

4. Common Screening and Assessment Tools

The morning presentation on a common screening and assessment tool that is in place in London was instructional and highlighted the benefits and effectiveness for women and for providers when common approaches to screening and assessment are in place. Participants at the workshop

supported the idea of developing a common tool that would work across sectors and that would include:

- Common tools
- Make screening by telephone possible
- Eliminate duplication for women
- Focus on building relationship with women
- Consideration of the woman's right to privacy and to choose when she discloses information
- Uses clear language that works for women and providers in all sectors
- The development of the screening tool would include women
- Includes a flow chart that helps providers and women know the next steps following screening and assessment.

Action Items for Common Screening and Assessment Tools

- Partner with Women's Mental Health and Addictions Action Research Coalition for pilot project to implement the London screening tool.

5. Intersector Communication and Intersector Case Coordination

Women with concurrent issues use many services over long periods of time, and face both internal and external barriers to service (difficulty identifying their issues, trust issues, fear of authority, poverty, lack of transportation, control by their abuser, parenting issues). They need providers with a high level of communication and coordination who act as case managers across sectors as they deal with their complex needs and issues. Information sharing, networking and case management strategies will improve service delivery for women.

Action items for intersector communication and case co-ordination include:

- Information sessions on what and how community agencies provide services (for providers and consumers), for example through lunchtime networking sessions.
- Shared video conferencing (need to develop this capacity and address access)
- Establish a listserv to exchange information and resources, and post information on a central community website (for example: www.endabusenow.ca)

- Provide information for women on how their information is shared, how the system works, where they can access information
- Designate people within in each agency who act as contacts for information and consultation on concurrent issues.

6. Joint Training

Many more service providers in key sectors need the training, networking and information sharing opportunities that were presented at the workshop. There is a need for a repeat of the No Wrong Doors workshop format for all providers in mental health, addictions and VAW sectors, as well as providers in the child welfare, justice and health care sectors.

Action items for joint training include:

- Intersector training for front line staff on early identification, screening, asking questions, responding to disclosures (what to do when you find out), specific training on addictions, mental health, abuse and the impact of abuse, and child protection.
- Intersector management training on intersector collaboration; trauma informed service delivery, new directions for rural communities, building shared values and service goals for collaborative work.
- Intersector training needs to include face-to-face opportunities for networking and relationship building for staff from various sectors.
- On line training opportunities on a website that can be accessed by all (for example: www.endabuse.ca)

The research findings and recommendations from the Community Strategies workshop and No Wrong Door workshop provide the basis for a community plan to improve service coordination and to address gaps in service for women with concurrent issues in Grey and Bruce. Participants from a broad range of community agencies and sectors at the No Wrong Door workshop endorsed moving forward with five priority action items.

The Next Steps in this process include:

1. Distribution of this report to community stakeholders, regional and provincial planning bodies, and provincial funding bodies.
2. Presentation of the key findings and action items to the Grey Bruce Violence Prevention Coordinating Committee with the recommendation that GBVPCC support the development of a short and longer-term implementation plan for the action items outlined in this report. The GBVPCC has already committed funding for an intersector training event in

2008-2009 to enhance collaboration between mental health, addictions and VAW services.

3. Presentation of the key findings and recommended action items to the Grey Bruce Concurrent Disorders Working Group and the Grey Bruce Mental Health and Addictions Network to look at ways to include the results of this study in planned training for mental health and addictions workers in Grey and Bruce.
4. Presentation of the key findings and action items to the senior managers of Mental Health Grey Bruce partnership for support for the development of a short and longer-term implementation plan for the action items in this report.
5. Presentation of the key findings and action items to Local Health Integration Network, southwest region, for support for the development of an implementation plan.
6. Prepare a funding proposal to Status of Women Canada to develop leadership for women who have used services and wish to take an active role in improving service coordination in Grey and Bruce.
7. Support the implementation of common screening tools for addiction, mental health and abuse issues by: pursuing involvement with a province wide initiative to develop and implement a common abuse screening tool, and coordinating abuse screening with screening and assessment initiatives underway in the mental health and addiction sectors.
8. Investigate other sources of provincial and federal funding to further develop and implement the recommendations from this report.
9. Develop a planning process that establishes a group with provider and service user representation, supported by leadership, to complete a system review and change plan based on the recommendations of this report, and that complements current collaboration initiatives in Grey and Bruce.

The Rural Strategies for Women with Abuse, Mental Health and Addiction Issues project successfully engaged women who use services because of concurrent issues and providers from a broad range of community services in Grey and Bruce in a research and community development process. The project has generated new information from the perspective of both consumers and providers of service in this rural community about how women seek help for concurrent issues, how community services respond, and the current status of service and system coordination in Grey and Bruce. Community stakeholders were involved in a review of the findings from current literature and the community research and in the development of

community strategies and priorities for action. The research and community development process was largely a positive and hopeful exercise that points to many opportunities for change that all participants believe is critical for our rural community.

There is a great need for a change in the way the mental health, addictions, VAW and other community sectors and services provide respond to women who are vulnerable and most in need of an informed comprehensive and coordinated delivery of service. Women said they need a delivery of service that is trauma informed and helps them identify and get help for the many complex issues in their lives. They need and deserve a collaborative community service response where there is No Wrong Door.

::: Introduction :::

Victims of woman abuse who also struggle with mental health and addiction issues have complex needs that span health, justice, social service, violence against women, child welfare and First Nations services. The community services that women need are largely organized within distinct sectors that are guided by specific mandates, funding parameters, philosophies and treatment approaches. In rural communities such as Bruce and Grey Counties, women with concurrent issues face additional barriers to service because of isolation, poverty, the lack of transportation, the lack of affordable housing and childcare, limited services for Aboriginal people, and a general lack of women -specific services. Women in Grey and Bruce Counties who are dealing with concurrent abuse, mental health and addiction issues need an approach to service delivery that integrates and coordinates services and sectors and makes the best use of limited resources. The service response needs to recognize and respond to the complexities and barriers facing vulnerable women with multiple issues.

"Violence is pervasive in the lives of women and children. The effects of trauma are substantial, impacting one's physical, mental, emotional, spiritual, social and economic well being. The inter-relationships among violence, mental health, and substance abuse are profound. Despite this reality, current services and service systems are inadequate in identifying and meeting the needs of women affected by trauma, mental health and substance abuse."
(Moses et al, 2004)

This report recommends a 'No Wrong Door' community approach to service delivery for women dealing with abuse, mental health and addiction issues. It captures the experiences, knowledge, recommendations and visions of women who use community services, and the men and women who provide them. At the end of a one year research and community development process the project participants called for an integrated and trauma informed approach to service delivery across the mental health, addictions, violence against women, justice, child welfare, and health and social service systems. A 'No Wrong Door' approach will ensure that every service door is a place where women with concurrent issues can find information, support, healing, and help.

The project was carried out by the Grey Bruce Violence Prevention Coordinating Committee (GBVPCC), a multi agency community committee dedicated to ending abuse and violence in all its forms in Grey and Bruce. The Children's Aid Society of Owen Sound and the County of Grey was the sponsoring agency for the project, with funding from the Victim Services Secretariat of the Ontario Ministry of the Attorney General.

In August 2007 the GBVPCC launched the Rural Strategies for Women with Abuse, Mental Health and Addiction Issues project to explore the following questions.

- What are the current capacity and coordination challenges for service sectors involved with abused women with mental health and addiction issues?
- How can services and supports use existing resources to improve service coordination and service delivery?
- How can sectors work together to address service gaps and capacity issues that compromise the safety, health and well-being of victims of woman abuse with complex needs?

The GBVPCC identified the need for the project through their Community Report Cards on Domestic Violence in 2004 and 2005ⁱⁱ. The Report Card process collects information from service users and service providers on the community response to abused women and children. Service users and providers identified the need for: intersector training, screening and safety planning for community service providers around abuse issues, more service coordination, more services for women with mental health and trauma issues, and action to address service barriers for abused women with mental health and addiction issues.

"That no woman impacted by substance abuse, violence and mental health concerns remain invisible and voiceless in the shadows of fragmented services and systems"

Consumer/Survivor/Recovering Women: A Guide for Partnerships in Collaboration (2001)

In March of 2006 the GBVPCC brought together key sectors from hospital and community based mental health services, addictions, Violence Against Women (VAW), justice, child welfare and First Nations services to discuss the need for new strategies to address issues facing women and the service system when there are concurrent mental health, addiction and abuse issues. There was broad community support for a research and community development project to explore service gaps and capacity issues, and to develop strategies for a more coordinated and effective service response for women.

When funding was confirmed in August 2007, the Mental Health, Addictions and Abuse Action Committee was struck as an Advisory Committee to guide the Rural Strategies project. The committee included representation from community mental health services, adult addiction services, violence against women services and two women who used community services. The members of the Advisory committee and their affiliation are listed in Appendix 1.

::: Definitions :::

Throughout this report there will be terms used that require definition:

Abuse

The definition of abuse for this project included all forms of *child abuse/neglect, child sexual abuse and child witnessing adult conflict* as described in the Child and Family Services Act, and **woman abuse** affecting teen and adult women (physical, emotional, sexual, spiritual, financial abuse as described in the Grey Bruce Community Response Protocol for Sexual Assault and Domestic Violence).

Mental Health Issues

In this study mental health issues are defined in the context of mental health, mental illness, and mental health problems as follows:

Mental Health The successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity.

Mental Illness The term that refers collectively to all mental disorders, which are health conditions characterized by alterations in thinking, mood, or behaviour (or some combination thereof) associated with distress and/or impaired functioning.

Mental Health Problems Signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder.

Source: DHHS (1999)ⁱⁱⁱ

Substance Use and Addiction

Substance use is the use of a substance(s) (alcohol, legal and illegal drugs) on a continuum from low risk use, to moderate risk use to high-risk use. Both moderate and high-risk use can lead to dependence and addiction. The definition of addiction in this study includes addiction to substances and gambling addiction. Another word for addiction is "dependence". A person can have a psychological dependence (the person feels he or she needs the drug to function or feel comfortable) and/or a physical dependence (a person's body has adapted to the presence of a drug and when the drug use stops, symptoms of withdrawal occur). Source: Centre for Addiction and Mental Health^{iv}

Concurrent Issues

In this study the term concurrent issues refers to women who experience abuse as well as addiction and/or mental health issues. In addiction and mental health services there is a similar term, concurrent disorders, which

generally describes a situation in which a person experiences a psychiatric disorder and either a substance use disorder and/or a gambling disorder.

Networking

A loose and flexible link between community groups/agencies where roles are loosely defined. People come together for dialogue, to share information and to create a base of support. Communication is informal and there is little decision making. An example is interagency lunches or networking events.

Coordination/Partnership

Service Coordination involves a central body of people that includes decision makers where there are defined roles and formal linkages between the groups/agencies. There is formal communication within the group, new resources, a shared budget and complex decision making. People come together to share resources in order to address common issues or create something new. An example is the Grey Bruce Violence Prevention Coordinating Committee.

Collaboration

Service Collaboration involves groups/agencies that work together in an interdisciplinary team to manage the health/welfare of a select group of consumers effectively and efficiently. Decision making is shared and roles are formalized with written agreements. Communication is highly developed, as is the level of trust, leadership and productivity. People come together to accomplish a shared vision and to build a system to address issues and opportunities. An example is Mental Health Grey Bruce, which provides mental health services in specific geographic areas through multi agency community mental health teams.

Integration

Integration is a strategy to accomplish collaboration in order to: improve access to comprehensive services, reduce service duplication, and to establish greater accountability. Integration strategies can take place at the service and/or system level:

Service integration strategies are aimed to change delivery of service for individual clients and include: coordination of services, joint case planning and management, common procedures and practices, integrated counselling modes, wrap around services, continuous treatment plans.

System integration strategies are aimed to change service delivery for a defined population as a whole and include: shared goals, interagency coordinating bodies, strategic planning, cross training, co location of services, policy work, formal partnerships, pooled or joint funding, centralized authority, identified system integration staff. ^v

::: The Project Goal and Objectives :::

Goal

To identify community strategies to improve intersector service coordination and to address service capacity issues and gaps in service for victims of woman abuse (domestic violence, sexual abuse) with mental health and/or addiction issues.

Objectives

1. To identify gaps in service for women with abuse, mental health and/or abuse issues
2. To hear from women how to better meet their service needs.
3. To develop community strategies to improve service delivery through coordination and training.
4. To develop community strategies to address service gaps that compromise the health and safety of women with multiple needs.

::: Project Methodology :::

Participatory Action Research

The Rural Strategies project used a participatory action research approach (Barnsley and Ellis, 1992) ^{vi} to hear directly from women who used community services, and from community service providers from key community agencies and sectors, about their experiences and their recommendations for change.

“Action research, in its most effective forms, is a phenomenological (focusing on people’s actual lived experience/reality), interpretive (focusing on their interpretation of acts and activities), and hermeneutic (incorporating the meaning people make of events in their lives). It provides the means by which stakeholders – those centrally affected by the issue investigated- explore their experience, gain greater clarity and understanding of events and activities, and use those extended understandings to construct effective solutions to the problem(s) on which the study was focused.”

^{vii}

The devastating impacts of violence on women are profound...many service providers do not recognize or understand the multiple, varied and complex impacts of violence. Symptoms may not be readily apparent or may be misunderstood when masked by seemingly unrelated behaviour. Standard approaches to mental health and substance abuse treatment and other human services may re-traumatize women who have experienced violence, setting back their recovery or causing them to refuse care. (Moses, D. et al 2003)

Project Phases

Phase One - Literature Review

The project work began with a Literature Review and annotated bibliography that focused on the integration of services for victims of woman abuse with mental health and addiction issues in a rural setting. The literature review looked primarily at recent Canadian literature; however, research from the United States and England were also included for their pioneering contribution to this relatively new field of study. The Literature Review, which was updated July 2008, is attached as Appendix 2.

Phase Two – Research and Data Analysis

From November 2007 until March 2008 information was gathered from women who used community services because of abuse, addiction and mental health issues, and from service providers from health, justice, violence against women, child welfare, and First Nations sectors and services. The data from focus groups and interviews with women and an electronic survey of service providers was analysed and a gap analysis report was prepared. The gap analysis is attached as Appendix 3.

A preliminary report on the findings from the research with service users and providers was prepared and used in two community workshops to develop community strategies attended by people who participated in the research phase.

Phase Three – Development of Strategies and Action Plans

Two community workshops took place to review the findings from the research and to develop strategies and action plans. The workshops engaged women who participated in focus groups and interviews and service providers from a broad range of community service providers.

The first ***“Community Strategies”*** workshop was held in April 2008. An equal number of service providers and service users were invited to attend an in depth facilitated discussion that used a World Café process to build relationships and share knowledge between providers and consumers and between providers from different service sectors. The workshop brought together diverse perspectives and experiences to review the preliminary findings from the research and begin the work of developing Community Strategies to improve service delivery for women with concurrent issues.

In June 2008 the ***“No Wrong Door”*** workshop brought together service providers from health, justice, social services, VAW, child welfare and First Nations services, and service users for training on integrated models of service delivery and a facilitated workshop process to identify priority

strategies and community action plans for a more collaborative service response for women with concurrent issues.

The Project Advisory Committee

The Mental Health, Addictions and Abuse Action Committee provided advice and guidance on the development of the information gathering tools and reviewed the preliminary findings from data collected from service users and providers. The committee provided input for the Gap Analysis and reviewed strategies developed at the community workshops. Some Advisory committee members participated in the focus groups and community workshops, and one committee member provided detailed strategies for inclusion in this report.

Project Consultants and Researchers

The project was developed and managed by Colleen Purdon. The development of the research tools, focus group facilitation, data collection and analysis was completed by Colleen Purdon and May Tettero. The final report was prepared by Colleen Purdon, with input from May Tettero and members of the Advisory Committee.

::: Project Participants :::

Service Users

A total of **thirty-six (36) women** who used community services because of addiction, abuse and abuse issues participated in the information-gathering phase of the project between January and April 2008. Thirty-two (32) women in Grey and Bruce Counties participated in focus groups and four (4) women came to individual interviews. Women provided information on their experience of the way community services were delivered and on service connections and coordination. They made recommendations on ways to improve services for women with concurrent issues.

Community agencies from the addictions, mental health and VAW sectors supported the information gathering process by inviting the researchers to attend existing groups. They provided space, staff support, invited women to attend the focus groups, and put individual women in touch with the researchers for interviews.

The following chart shows the service sectors that hosted focus groups and the geographic locations and number of participants:

Mental Health	Violence Against Women	Addiction
Grey Bruce Health Services DBT Group Owen Sound 5 participants	Women's House Serving Bruce and Grey Kincardine 5 participants	Withdrawal Management Owen Sound 5 participants
CMHA Bruce Shoreline Port Elgin 5 participants	The Women's Centre Second Stage Housing Owen Sound 5 participants	
CMHA Bruce Shoreline Kincardine 7 participants		
Total participants 17	Total participants 10	Total participants 5

Of the four (4) women interviewed, two (2) were currently receiving mental health services and had used VAW services, and two were past users of VAW and Mental health services.

Women who participated in the research and community workshops reflected the population of the area, and came from diverse backgrounds and communities in Grey and Bruce, including First Nations women. Each woman was given an information package about the project and signed a consent form. Focus group and interview participants were encouraged to attend the follow up community strategy workshops. The facilitators assisted women with transportation needs to attend. Each participant received a small honorarium to cover childcare, transportation and out of pocket expenses.

In Phase Three of this project (Development of Strategies and Action Plans), eleven (11) women who took part in the focus groups and interviews attended the Community Strategies workshop and seven (7) women attended the No Wrong Door workshop.

Service Providers

Seventy-one (71) service providers responded to an electronic survey (Survey Monkey) between December 2007 and March 2008. They provided information on screening, assessment and intake procedures, response to disclosures of abuse, community resources, and service collaboration for women with concurrent abuse, mental health and addiction issues. Forty-nine providers completed the survey for a completion rate of 69%.

The survey respondents came from a variety of sectors and community agencies. The chart below outlines the source of responses:

Sector	Response (%)	Response (n)
Mental Health	28	20
Substance Abuse	13	9
Violence Against Women	24	17
Other	35	25
Total	100	71

Other sectors and agencies that participated in the survey included: Justice (municipal and OPP police services, Probation and Parole), Child Welfare, Community Based Supportive Housing, Aboriginal Healing and Wellness, Public Health. Ninety percent (90%) of the service provider respondents were female.

Respondents included:

Senior Management n=6

Supervisor n=7

Front Line Worker n=49

Other n=7

Total n=69

(Agency Board member, Self Employed, Middle Manager, Community Representative of a Provincial Organization)

In general, the survey respondents represented the key sectors and community agencies where women find help for their mental health, addiction and abuse issues in Grey and Bruce Counties.

In Phase Three of this project (Development of Strategies and Action Plans) eleven (11) service providers from a broad range of health, community mental health, addictions, VAW and child welfare services attended the Community Strategies Workshop, and fifty-five (55) providers attended the No Wrong Door workshop. The sector and agency representation at the No Wrong Door workshop was excellent, with all of the key sectors and agencies represented, including First Nations services.

Limitations

The data collection and development of recommendations in this report are influenced by the following limitations:

- Participation in the electronic survey of service providers was voluntary and represents the perspective of people who were interested in responding. The findings from the service provider survey may not represent the full diversity of opinion or knowledge across community sectors and services.
- Focus group and interview participants were connected to this project through their relationship with service providers. The data does not include the perspective of women with mental health, addiction and abuse issues who are not currently connected with a community service.
- The number of focus group participants from the addiction sector was much smaller than from mental health and VAW sectors, which may influence the findings in the report. In addition, the participants in the addiction focus group included several young women and this may influence the number and types of services used.
- First Nations women were under represented as focus group and interview participants. A focus group at a First Nations community was planned but did not take place due to other community commitments. First Nations women were represented at the community strategies workshops, as consumers and providers.
- The consultation with women focused on their experiences with services and supports in Grey and Bruce Counties, but women often spoke of experiences in other communities, or past experiences. Some of the data may reflect women's experiences with other community services.
- There were some problems with the quality of the audio tapes from some focus groups, which made a verbatim transcription from some of the focus group difficult. Every effort was made to transcribe the input from focus groups accurately, but in some cases it was difficult to hear women clearly. Written notes were made for all focus groups. Data was compiled from the transcripts (when available), hand written notes, and a review of the audio tapes by the focus group facilitators.
- The preliminary analysis of the data from focus groups and interviews was completed by the focus group facilitators, who have an extensive background in the violence against women sector, as service providers and researchers. Their background and experience is reflected in the data analysis.

::: Data Collection & Analysis :::

Data Collection Tools and Processes

A number of approaches and tools were used in this project to collect data:

- A web based **Service Provider Survey Tool** (Appendix 4) using Survey Monkey technology was developed with input from the project advisory committee. The service provider survey was distributed to all members of the Grey Bruce Violence Prevention Coordinating Committee, and to the leadership within the mental health (hospital and community based services), violence against women, addictions, and First Nations services with a request that it be distributed to staff in their respective agencies. The Service Provider Survey provided qualitative and quantitative data on screening and assessment processes, response to disclosures, community resources, and community collaboration and best practices. The data was collected and collated by Survey Monkey.
- A **Focus Group Question Route**, (with a consent form, and project information package (Appendix 5) was developed with input from the project advisory committee. The focus groups collected information from women on: reaching out for services, their experience of services, service access, coordination and connections between services, and recommendations for improved service delivery. The focus groups were taped with consent from participants and a transcript was prepared. Unfortunately the quality of the taping was poor for some focus groups and some of the resulting transcripts were of limited use. Handwritten notes from the focus groups were used in conjunction with the transcripts, to collect data from service users. Focus groups were organized and held at various organizations from three sectors: mental health (hospital and community based service), substance abuse, and violence against women.
- An **interview guide, consent form and information package** was prepared for individual interviews with women. The interview guide was based on the focus group questionnaire. (Appendix 6). Interviews were taped and transcribed, and hand written notes were taken to collect data from women.
- A **Mapping Exercise** was completed by 25 women who participated in the focus groups and interviews. The exercise allowed women to provide information on their path to community services, which services they accessed, as well as data on the type of mental health, addiction and abuse issues they were dealing with. A copy of the mapping exercise is attached as Appendix 7.
- A **World Café Process**^{viii} was used to collect data on community strategies at the **Community Strategies Workshop**. The World Café engaged an equal number of service users and service providers who had

participated in the research phase of the project in the development of community strategies. The World Café is a facilitated process that brings people together to have a 'conversation that matters'. Participants provided data in writing, and their verbal summaries of their discussions that were captured in flip chart notes made by the facilitators. The agenda for the workshop is attached as Appendix 8.

- A **Facilitated Workshop process** was used to collect data from the perspective of service users and providers on priority community strategies and action plans at the *No Wrong Door Workshop*. Data was provided by participants in writing and from verbal reports captured on flip chart notes. The agenda for the workshop is attached as Appendix 9.

Data Analysis

1. **Service Provider Survey:** The collated data from the responses of 71 participants in the service provider survey, and a summary prepared by the project coordinator was presented to the Project Advisory Committee for discussion and analysis. Key issues, gaps in service and community needs were identified from the data and a summary of service provider findings was prepared.
2. **Focus Group and Interview Data:** The project consultants prepared a summary of key themes, issues and recommendations from the transcriptions and notes of focus group and interview data. A summary of findings was prepared and presented to the project advisory committee and at two community workshops to develop strategies.
3. **Mapping Exercise Data:** The project consultants collated the data from 25 maps completed by women. Data was collected on the types and number of community services used and the types and number of mental health, addiction and abuse issues those participants in the focus groups and interviews experienced. Comparisons were made across sectors. The consultants looked at patterns in the way women used community services, and linkages between service use and the issues they experienced. This data was summarized in a report that was included in the preparation of the summary of findings for the project advisory committee and community workshops.
4. A **Gap Analysis** was completed using the data collected from service provider and service user perspectives. The members of the project Advisory Committee identified key issues, gaps in service and the desired future in the Gap Analysis, based on data from the Literature Review and community consultation.

5. A **Summary Report of Key Themes** from the data from the Literature Review, the Service Provider Survey and the Mapping, Focus Group and Interview process with Service Users was compiled by the project consultants, and used in the community workshops.
6. The data from the Communities Strategies workshop was summarized by the project coordinator in a **Community Strategies Report** that included 19 strategies and a priority ranking completed by participants at the workshop.
7. The data from the **No Wrong Door Workshop** was summarized in a report prepared by the project coordinator that set out recommendations and preliminary action plans in six areas identified by workshop participants.
8. All sources of data were used to prepare this **Final Report** and recommendations for next steps.

::: Findings from the Research :::

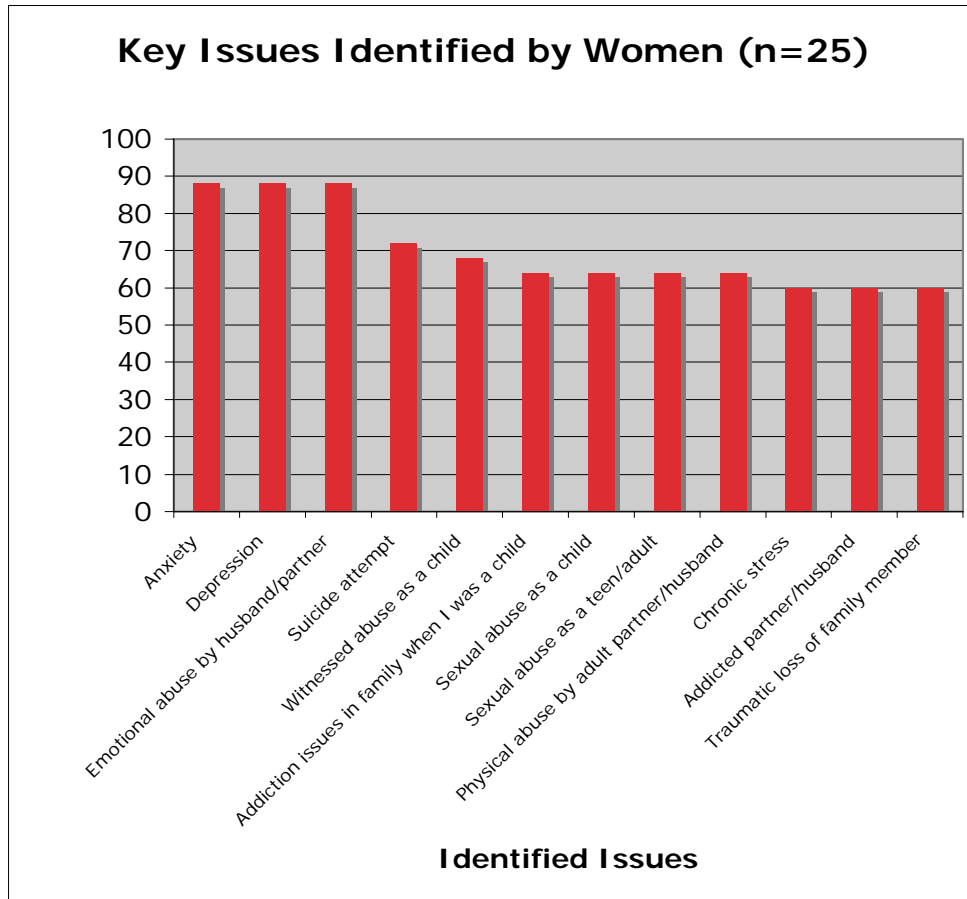
The project findings are a summary of key themes from information collected during Phase One and Two of the project (Literature Review, Focus Groups and Interviews, Survey of Service Providers). They are arranged under four main headings: Issue Identification, Getting Help, System and Service Coordination, and The Need for Change.

1. Issue Identification

Women experience a range of complex, interrelated issues

The mapping exercise completed by 25 women provides insight into the kinds and range of mental health, addiction and abuse issues reported by women who participated in the focus groups and interviews. All (100%) of the women experienced some form of abuse during childhood, in their teen years, and /or adult years, and many women experienced multiple forms of abuse, beginning in childhood and continuing to the present. Sexual abuse (as a child or adult) and emotional abuse by a partner were both experienced by 88% of women in this study. Most women (88%) experienced mental health issues (depression, anxiety) and almost two thirds (64%) experienced addictions in their family of origin.

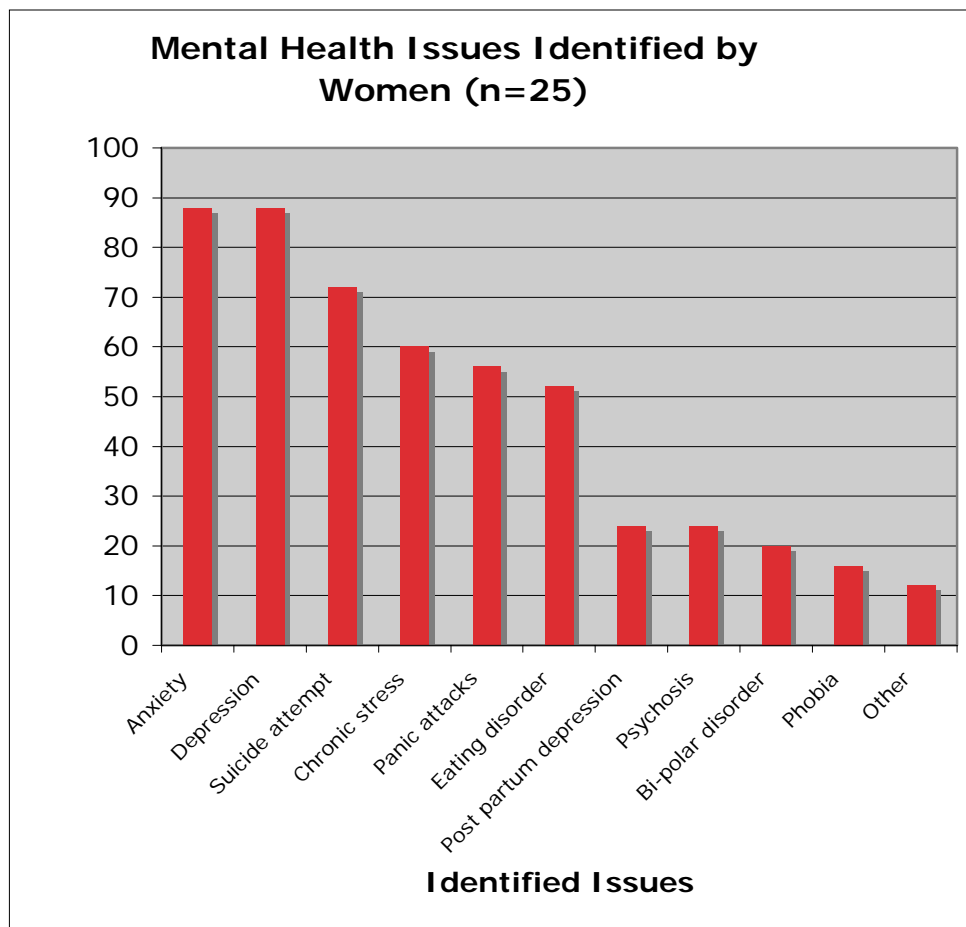
The chart below is a ranking of the top issues identified by 25 women in their maps:



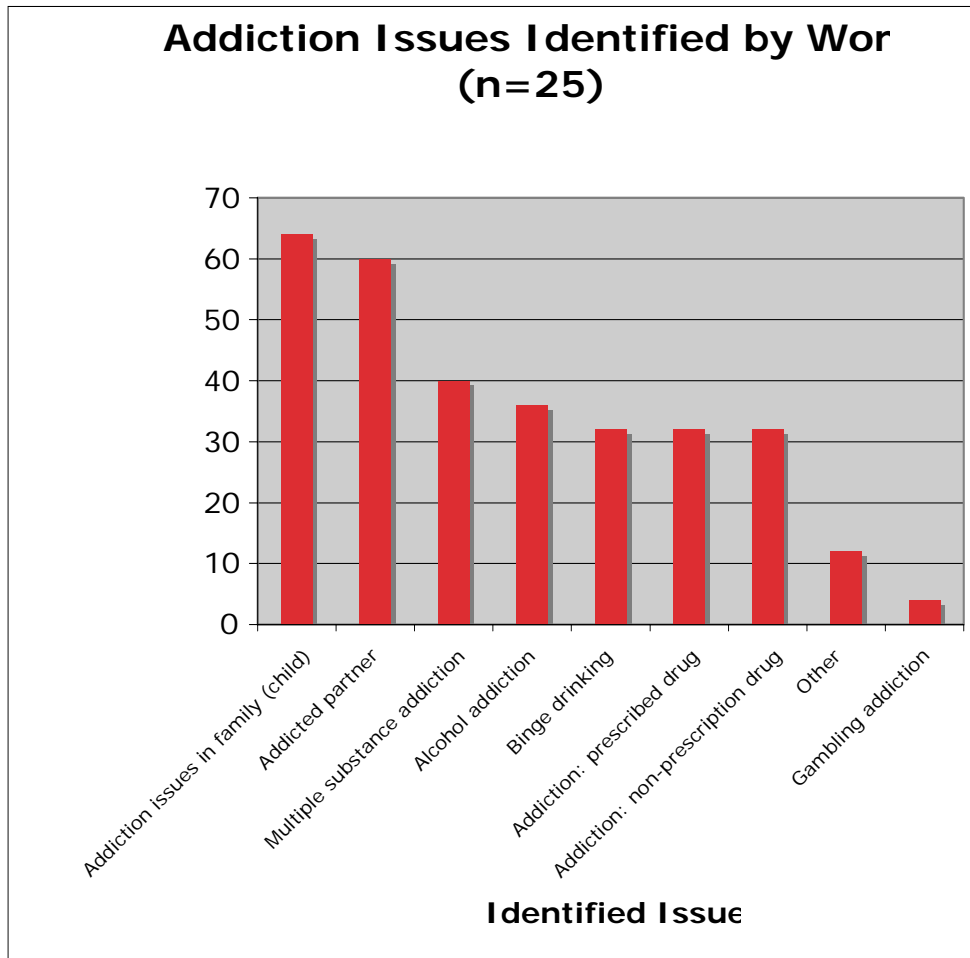
- Twenty-two women (88%, n=22) women reported experiencing some form of sexual abuse in their life. 64% identified sexual abuse as a child, 64% identified sexual abuse as a teen or adult, and 52% reported that they were sexually abused by their partner/husband.
- Anxiety, depression and emotional abuse by the woman's partner were reported by 88% of women.
- 72% of women reported suicide attempts. Some women noted on their maps that they had multiple suicide attempts. These high rates indicate that women with concurrent issues are at great risk of harm to themselves.
- Witnessing abuse as a child (68%) and growing up in a home where there were addictions issues (64%) were reported by about two-thirds of the women. The negative impact of chaotic and violent homes on the development of children is well researched.^{ix} Over half of the women (52%) also reported that they experienced child abuse/neglect, which indicates a high level of childhood trauma for participants in this study.

- 64% of women reported experiencing physical abuse by their partner/husband. Another 60% said they had an addicted partner/husband. The high levels of abuse (emotional, physical, sexual) and addiction issues with intimate partners, suggests that many women with concurrent issues cannot rely on support or help with their pre-existing difficulties at home, and in fact are more likely to experience ongoing or new trauma within their intimate relationships.
- 60% of women reported chronic levels of stress in their lives and 56% of women reported experiencing panic attacks.
- Women with concurrent issues also report a high level of traumatic loss. 60% said they experienced a traumatic loss of a family member, and 40% experienced a traumatic accident, which indicates that many women had multiple exposures to different forms of trauma.

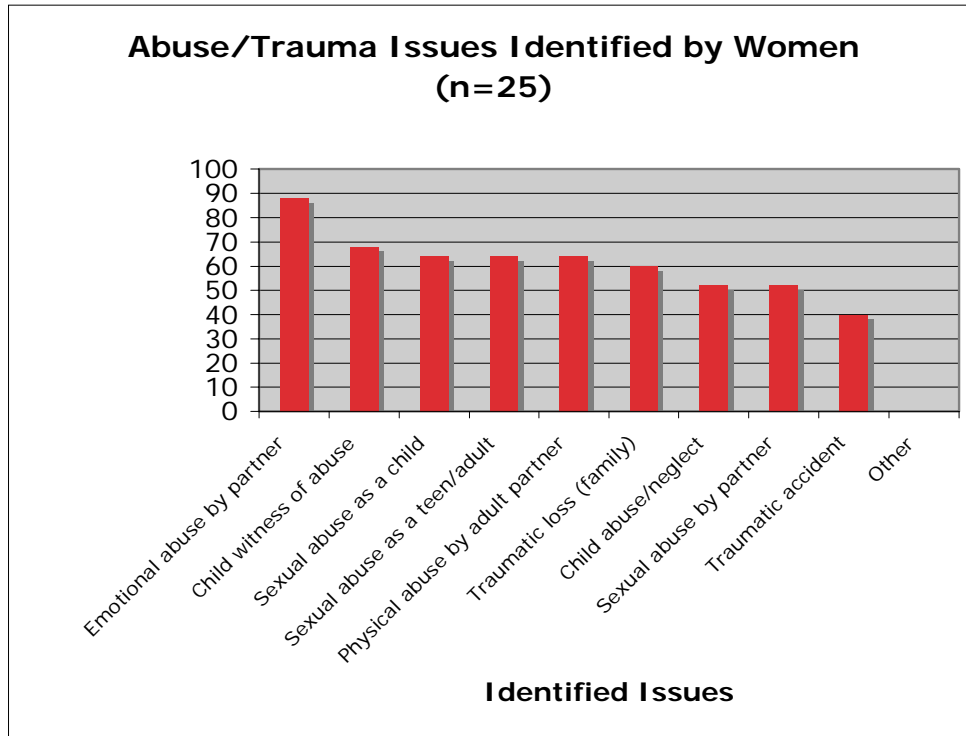
The three charts below summarize the mental health, addictions and abuse/trauma issues as identified by women in their maps:



Other: Multiple Personality (8%), Self Injury (4%, n=1).



Other: Cigarettes (8%), Sex Addiction (4%, n=1)



“One issue follows another”

Women reported a similar number of mental health, addiction and abuse/trauma issues, regardless of which sector/agency they were involved when the focus group took place. This indicates that the range and types of issues that women are dealing with are rather similar, regardless of the point of service where women find themselves.

According to a recent study by the Women’s Mental Health and Addiction Action and Research Coalition, “85% of women with mental health or substance use problems had experienced physical, sexual or emotional abuse”. (Buttery, 2003)

The maps suggest the experience of abuse, precedes all other issues. Most women in this study experienced mental health, addiction and abuse in their adult relationships following exposure to sexual abuse and/or witnessing abuse as children. Every woman in this study experienced some form of abuse and trauma, and many women experienced multiple forms of abuse from childhood until the present. In addition, many of the participants continued to be vulnerable to ongoing harm from abusive partners, and some women in this study feared for their safety at the time of the focus group or interview.

Identifying issues can be difficult for women

Women said they struggled to identify their issues.

“I’m just a lot of crazy”
(Focus group participant)

They described feeling bad, feeling pain, being overwhelmed, feeling worthless and not knowing why. They could not identify the problems, but only knew that things were not right. Many women

said they felt 'crazy', a global sense of helplessness and confusion that made it difficult to reach out for help. Women said that they needed help to recognize what their issues were, and that they struggled to reach out for help because they didn't know what was wrong.

Women first identified issues as a result of a crisis.

Some women reported that they first became aware of abuse, mental health and addiction issues as a result of crisis interventions by police, child welfare, health, addiction and VAW services. The most frequently mentioned crisis was: a suicide attempt by the woman, an assault by a partner or ex partner, or a parenting crisis with a child/teen. Some women said that they were not taken seriously by family and professionals until they attempted suicide.

Women didn't get the information they needed to identify their issues, especially from family doctors.

Women said they needed clearer information from professionals, especially from their family doctors. Most women reported that they went to their family doctors first for help to find out 'what is wrong with me' and many reported that their doctors were reluctant or not as well informed as they needed to be around mental health, addiction and abuse issues. Women said that they got medication for help with symptoms, instead of help to identify their complex issues and information about community resources. One woman pointed out the window to her doctor's office down the street. She said she walked past the community mental health services for years on her way to her doctor, but found out about mental health counselling services from another source. She regretted that services that were available and so very helpful for her were never once recommended by her family doctor.

"Did my doctor see what was happening to me as abuse? He gave me the phone numbers for mental health services." (Focus Group Participant)

Women said they needed much more information and education about mental health, addiction and abuse issues from professionals who could 'name the issues clearly'. They asked for more information and resources on the impact of these issues on their parenting and on their children.

"I really resent medications. I was overmedicated. All I did was sleep. I got too much and there was no monitoring. I missed years of my daughter's life." (Focus Group Participant)

Several women said more information from police on abuse issues would have helped them, and many women called for more information for children and teens on mental health, addictions and abuse as a preventative measure.

Abuse issues are difficult for women to identify.

Many women who were victims of childhood abuse said did not identify these issues until they were adults, and often after they had been receiving services for mental health, addiction, and/or adult abuse issues for many

years. One woman said that when she was sexually abused as a child by a family member her family did not tell the CAS what was truly going on. She forced herself to deny the abuse and had been in various forms of treatment for behavioural and mental health issues from her teen years until the present.

Many women involved in this study said that abuse issues were not identified or talked about as part of their mental health and/or addiction treatment.

"It is really unfortunate that I didn't get help when I was a little kid. I needed help."
(Focus Group Participant)

Several women were angry and frustrated that they were involved in ineffective mental health treatment for years where their childhood trauma or current partner abuse was not identified or considered in treatment. Being part of the system, struggling with the side effects of medication, and not getting "better" had a profound impact on their health, sense of self, and personal safety.

"I masked my issues with drinking. Then I stopped. Then things fell apart. Now I'm on meds, sedated, and not feeling any better."
(Focus Group Participant)

One woman arrived at a focus group and said she didn't think she should stay because she had never experienced abuse. She stayed anyway, and during the focus group realized she had been abused by her partner many years previously. She did not know that being pushed and slapped is a form of abuse.

Several women were surprised to self-identify abuse issues when they completed the mapping exercise, which listed different forms of abuse.

When women don't identify abuse, they do not recognize the link between their mental health and/or addiction issues and the trauma they experience.

Women in this study said that not identifying the abuse in their lives, and not understanding the link between abuse/trauma and their mental health and/or addiction issues had a negative effect on their safety, the safety of their children, their self-confidence, and their treatment choices and outcomes.

"It was so long before I knew I was abused. Women need to be much better informed, especially around financial control and emotional abuse."
(Interview Participant)

The abusive partners in women's lives make it difficult to identify the issues.

Women involved with abusive partners said that their current or ex partners intimidated, brainwashed and controlled them, and at times these behaviours extend to service providers as well. The abusive partner interfered with her attempts to get help, told her she was crazy, blamed her, and undermined her self-confidence. Some women who experienced childhood abuse did not identify abuse issues because of the influence and denial of their abusers that

"Women are often not sure what the main problem is and believe that one thing is causing all of their problems."
(Survey Respondent)

continued on into their adult lives.

Identifying women’s issues through agency screening and intake processes.

The survey of service providers asked for information about screening and intake procedures and tools when women access mental health, addiction and VAW services.

Service providers indicated the issues they routinely screen for:

Issue	Response Percent
Physical Abuse	93%
Sexual Abuse	93%
Mental Health Concerns	88%
Emotional Abuse	84%
Substance Abuse Concerns	82%
Childhood Sexual Abuse	66%
Childhood Abuse	64%
Total	N=56

Service providers indicated a high level of routine screening for adult abuse and mental health issues, with a slightly lower rate of screening for substance abuse. The lower rate of screening for child sexual abuse and childhood abuse is of concern, given the high incidence of these issues reported by women in this study.

“Look for opportunities to bring it (abuse) up all along the way of screening, assessment, counselling and take the lead from the woman re: depth.”
(Survey Respondent)

Two thirds of service providers use an agency procedure or protocol to screen for issues as part of intake.

- About half (47%) of mental health service providers responded that there is no agency procedure or protocol to screen for abuse issues.
- The VAW sector has lower rates of screening for mental health issues (33%), substance abuse issues (66%), child sexual abuse (58%) and child abuse issues (50%).
- The Addictions sector had the highest levels of screening for all issues.

Most providers reported feeling comfortable or very comfortable asking questions about abuse/trauma, mental health and addiction issues, although some expressed concerns about being perceived as intrusive.

Several respondents noted that it is important to know what to do with information and to have a high level of expertise to screen for these issues. Some respondents recommended that it is good to ask women about abuse and trauma often, not only as part of screening, but at any time in the process

There is no common screening tool used across the various sectors and services in Grey and Bruce, and some organizations and providers do not use a formal procedure or protocol, or workers are not aware of these.

Discussion:

Women in this study reported that they knew they were not feeling well, and they were not coping with life's challenges but they had difficulty naming what was wrong, especially abuse and trauma issues that took place during their childhood. Service providers report a fairly high rate of screening for current mental health, addiction and abuse issues, but the way this screening is done, and the tools that agencies use is not consistent across sectors. Service providers also report much lower rates of screening for childhood abuse issues, which could be related to women's difficulties in identifying these issues.

Women who enter the service system as a result of a crisis may not be in a place where they can respond to screening and issue identification. Many women reported very low levels of trust, especially with authority figures, which interfered with their ability to work with providers in a way that would help them disclose abuse issues. They also reported high levels of confusion and shame, which impacted on their ability and readiness to identify painful and potentially embarrassing material. Many women said they lacked clear information about the issues, or were prevented from figuring out what was wrong because of an abusive partner or family member.

The data suggests a need for education, and a more proactive approach to issue identification that is based on standard screening tools and approaches, and a thorough understanding of the impact of abuse and trauma on mental health, addictions and adult abuse issues.

2. Getting Help

Needed services are not available

Grey Bruce, like many rural communities, has a doctor shortage and a critical shortage of psychiatrists. A large number of women in this study with mental health issues did not have access to a psychiatrist, and several women reported travelling outside of the area to London and Toronto to access psychiatric care.

Many women said they did not have a family doctor. They worried about using walk in clinics and emergency departments to deal with their complex health and mental health needs. Several women noted that they have no one to monitor their medication (medications that they know have serious side effects and a potential negative impact on their health), and they have to go to hospital emergency departments to have their prescriptions filled.

Women who used in-patient hospital mental health services reported a frustrating experience where it was very difficult to see a psychiatrist, and when they do, the focus is on medication only. They said there was no programming or counselling for them, and one woman said that she was given a pile of brochures of local services as a form of discharge planning. Two women said the services in Owen Sound were very different from treatment they received in Orillia and London, where there was a range of in patient programming that they experienced as extremely helpful.

There is no residential treatment program for women with substance abuse or mental health issues. Women need to leave their families and communities to access residential treatment, and there are long waits for these services. Several women said they did not get the follow up support they needed after leaving residential treatment in other communities and returning home.

Women said there were not enough affordable counselling services that could deal with their complex issues, and the long term service and support that they needed. Counselling services for mental health and historical sexual abuse issues were difficult to find. Some women said they were not “sick enough” to get mental health services. Over half (56%) of the women in this study used private counselling, often because they did not meet eligibility requirements for publicly funded services. Several women commented that they were fortunate to have benefit plans that paid for counselling services, but women without benefit plans or money struggle to get counselling services. Women said it was very difficult to find long term counselling to help them with their complex issues.

Women reported long waits for some counselling services, and services for their children. They said they need service models and hours of service that fit for working women. They identified a need for more emergency housing for women and children in Grey and Bruce.

Service providers and women said that there are not enough culturally appropriate services for Aboriginal women and their families. Service providers identified women with developmental challenges as another group where mental health, addictions and VAW services are very limited.

Service providers identified the following needed services in Grey and Bruce:

- Local residential treatment centre for women with addiction and mental health issues
- Emergency housing for homeless women and children
- Aboriginal services
- Services for women with mild to moderate mental health issues

- Centralized intake system that is available 24/7
- Integrated services (staff from all three sectors) at one site
- Women only programming for women with concurrent issues
- Practical assistance for women to overcome service barriers (transportation network, affordable housing, help with legal system, better income supports)

"I'm not sure if any new services or supports are needed, but the existing ones need to be better coordinated and working together." (Survey respondent)

Some service providers said that there are enough services, but they need to be better coordinated, and they need to be more readily available and long term for some cases.

Sectors and services frame what is 'wrong' with women

The mapping exercise and focus group data suggests that women come to understand what is wrong with them depending upon the service sector they access. Women with concurrent issues may be sent to a community service by a family doctor, be thrust into service because of a crisis, or seek out a service because of advice from family, friends or employers. The whole picture of her current and past issues may not be clear for the woman or the referring source when she accesses service. Each sector and service works from a different theory, philosophy and approach that can frame for women what is 'wrong' with them:

- The mental health sector and services frame her problem as mental illness. The treatment approach is medication, coming to accept and live with one's symptoms, and accepting the diagnosis. A bio-psychiatric and/or case management support model is used.
- In the addictions sector there are services and self help groups that frame her problem. They may frame her addiction as the disease of addiction, with the goal of sobriety or her addiction may be framed as a way of coping or self-medicating to deal her life situation. The goals may be abstinence and/or harm reduction. There are various treatment approaches and models that are not always consistent.
- The violence against women sector and services frame her problem as oppression and victimization through physical, emotional, sexual and financial forms of abuse. Interventions are based on a support and empowerment model where women are engaged in safety planning, choices and options, establishing independence from the abuser, and understanding the impact of the abuse. A feminist perspective, that places woman abuse within a larger context of women's inequality in society, informs VAW service approaches.

Women in this study appeared to learn to frame their issues through the lens of the service they use. This may make it difficult for them to identify other

concurrent issues, or the service approach may be too narrow to meet their complex needs. Women in this study said that they often felt they were not at the 'right' service to meet their needs, or they did not 'fit'.

Women said they needed a different approach, where sectors and services work together so women can:

- Identify childhood abuse issues earlier, and the impact of childhood trauma on current mental health, addiction and adult abuse issues.
- Get help to address all of the struggles and issues facing women, in a way that makes sense and does not focus on only one issue or difficulty
- Get help to access other needed supports and services from the service she first accessed. A referral alone is not enough.

There are barriers to getting help.

There was a broad consensus from service providers and service users around barriers to service for women with concurrent issues in Grey and Bruce.

The top *barriers noted by both providers and users* of service, listed in order of importance are:

- Poverty
- Lack of transportation
- Women don't know where to go first
- Women don't trust agencies
- Isolation and lack of information about services (who can access them, what they offer, how to access them, service location and hours, cost)
- Wait lists for service
- Lack of coordination between services and sectors
- Service does not address women's complex needs
- Location of services

"Services are lost to clients who do not have the initiative or trust level to maintain them, who miss appointments because of poverty, or can't access them. Rural women are disadvantaged." (Survey Respondent)

Additional barriers noted by service providers:

- Service providers do not share a common understanding of the issues
- Lack of training on concurrent issues
- Lack of case management/coordination
- Barriers because of different service philosophies and mandates

Women in rural areas experience more physical abuse and (the report) confirms that weapons form a part of domestic violence more often for rural women. Tettero identified lack of anonymity, social and physical isolation, stigma and shame, poverty, emphasis on traditional gender roles, fear and inconsistent service provision as key barriers for rural women seeking help. (Tettero, 2008)

Additional barriers noted by women:

- Lack of childcare
- Working women do not qualify for government assistance, or legal aid and don't have the money to get legal help.
- Abusive partners and ex partners hinder her access to service by isolating the woman, controlling access to medication, counselling, healthcare, transportation, telephone, family and friends. Abusers also undermine the woman's gains in counselling or become more violent and/or threatening as the woman begins to deal with her mental health, addiction and childhood abuse issues.
- Stigma. Women experience stigma and shame because of their mental health, addiction, abuse issues, which makes it hard for them to access services. Living in a rural community heightens one's sense of shame, as it is difficult to remain anonymous.

Strengths and weaknesses in the service response:

The focus groups with women and the survey with providers revealed current service delivery strengths and weaknesses:

Strengths:

- Over 80% of service providers report that they have a good or excellent knowledge of community resources in regards to mental health, addiction and abuse issues.
- There is a high level of referral (over 80%) to other agencies when workers encounter abuse/trauma, mental health, and substance abuse issues.
- Service providers report that they use multiple approaches to safety issues when women disclose current physical, emotional, and/or sexual abuse: use of safety planning tool (reported by 52%), referral to VAW (reported by 48%), consult with VAW (19%), consult with CAS (26%)
- Women identified a list of service responses that are helpful:
 - Crisis lines that are not time limited, and are staffed by knowledge people who can provide information on local services
 - Groups that bring women together, give women a voice, provide good information, answer questions about abuse, put things together, and provide practical and positive tools for women to manage their lives.
 - First response services (police, victim services, crisis response) that provide good information in a personal and supportive way and take an active role to connect women to other providers/supports.
 - Services that provide ongoing support and follow up, often over many years
 - Specific services like the DBT program.

- Services that understand the impact of current and past abuse on women; recognize that when a woman is in an abusive relationship and becomes stronger through counselling, the abuse may become more extreme
- Services that work well with other providers; services work together to provide the woman with a circle of support that allows her to take positive action for herself and children.

Weaknesses:

- A significant number of service providers reported poor or fair competence levels responding to specific situations:
 - 30% of providers reported fair/poor competence levels dealing with abuse/trauma issues
 - 24% of providers reported fair/poor competence levels dealing with mental health issues.
 - 35% of providers reported fair/poor competence levels dealing with substance abuse issues.
 - 35% of providers reported fair/poor competence levels dealing with women with concurrent mental health, addiction, abuse issues

When the data is analysed by sector:

- 40% of mental health providers reported fair/poor competence levels dealing with abuse/trauma issues.
- 37% of addiction providers reported fair/poor competence levels dealing with abuse/trauma issues.
- 33% of VAW workers reported fair/poor competence levels for both substance abuse and mental health issues.
- 43% of service providers reported that when they refer women to other services they are only available some of the time.

“Services need to be coordinated for women. I have run into situations where a woman with concurrent issues ended up with no support, as all of the services she had sought out continuously referred her to another service until she decided it was not worth the time or effort.” (Survey Respondent)

Only 6% of providers said services were available all of the time. This indicates that women often are not able to access the services they need.

- Although referral levels are high, there is often no follow up or support to help women bridge sectors and services, or coordination mechanisms for women receiving multiple services.
- Women identified a list of service responses that are not helpful:

- Services that provide information without a personal connection or a supported plan for follow up
- Services that do not identify present or past abuse, are not aware of the control that the abuser has over the woman, or that fail to understand and act on her physical and emotional safety issues.

“Women are overwhelmed just keeping their lives together. It’s so much ‘work’ to get help.” (Survey Respondent)

- A medication only approach that does not address issues of abuse and trauma in the woman's life.
- Too much medication (woman is sedated and cannot function); medication where any gain is overshadowed by side effects that undermine the woman's quality of life or ability to be in charge of her life.
- No proper follow up or monitoring of medication; or a trail and error approach where the woman bears the consequences and risk of adverse reactions; continuing with medication that does not improve the woman's quality of life, or her control over her life.
- Too much turn over of counseling staff, lack of continuity, and women needing to continually 'start again' with new providers.
- Services that make her feel responsible or blamed for her situation and issues, or services that defend or excuse the abuser's behaviour.
- Criminal and family court systems that undermine the woman's credibility and often expose her to manipulation by her abuser, particularly when a woman is the victim of extreme emotional and psychological abuse. The woman can also be left impoverished in the family court system, in protracted child custody and access battles with her abuser.
- Services with rules that do not accommodate the woman's needs (Shelters, In patient Psychiatric ward, CAS etc.); programs that do not address all her issues, and legislation that protects the abuser's privacy at the expense of the woman's safety and welfare (Privacy Act)

"Substance abuse is not frequently an issue. If it is, clients may attempt to avoid discussion it, as substance use is not permitted by clients while in shelter." (Survey Respondent)

What women need from community services

Women were very clear about what they need from community services. The following list is a summary of what women said they need from community services:

- *Early Interventions*, before the woman is desperate.
- *Information and Education* that names the issues provides information on services, the impact of trauma, rights, and options.
- A *Skilled and Compassionate First Response* that identifies the concurrent issues, helps her make sense of what is happening, connects her past and present, and connects her with ongoing supports.
- *Trauma Informed Mental Health and Addiction Services* to help women identify and understand how past and current abuse issues impact mental health and/or addiction issues.

"I was trying to get help for childhood sexual abuse. Because I was having a problem with addiction, she (the counsellor) wanted to stop the counselling and wait until I had that solved. But that was what was causing the problem. So I just gave up and didn't get help with either." (Focus Group Participant)

- *Groups* to meet others with similar struggles, to break isolation, de-stigmatize, build support systems, and to educate. A safe place in each community; a sense of community and belonging.
- *More Rural Resources* to address barriers to access (transportation, childcare, etc.) and confidentiality, anonymity
- *De-stigmatize* addiction, abuse, mental health problems and poverty
- *"Don't label me as sick"* - validate the woman's experience and help her put it in a context. Help the woman to solve the problems herself.
- *Counselling* that involves listening, careful pacing, thorough assessment, education, increasing self-worth, "a heart response", asking real questions, being believed, a systemic analysis so the woman understands 'it's not just me', honest confrontation, warmth, help women see their strengths, let their feelings out, counselling based on an authentic relationship, not just a role.
- Any place of "help" should be a *One-Stop Shop* to get information about abuse, addictions and mental health (as well as financial support, housing, legal services etc.)
- Any place of "help" needs to provide *Support and Follow up* for referrals, not just be a place to "go for counselling".
- A *Non-Institutional Approach*, and places that are healing, personal, flexible, accessible, comprehensive.
- *Consistent Care Over Long Term* (1 - 5 years) and where staff turnover is kept to a minimum.
- *Skills Training* in assertiveness, communication, self-soothing, social recreation etc.
- *Parenting Support*, and help for the woman's children.

Summary of Service Gaps and Capacity Issues

The following is a summary list of some of the key service gaps and capacity issues identified by providers and consumers through the research:

- Early interventions and prevention strategies
- Access to family physicians, psychiatrists and psychologists
- A recovery home for women in Grey and Bruce
- Information and education for women
- A voice for women in treatment and service planning/delivery

"Many service providers do not recognize or understand the multiple, varied and complex impacts of violence. Symptoms may not be readily apparent or may be misunderstood when masked by seemingly unrelated behaviour. Standard approaches to mental health and substance abuse treatment and other human services may re-traumatize women who have experienced violence, setting back their recovery or causing them to refuse care."
(Moses, D. et al, 2003)

- Trauma informed counselling services for women with mental health, addiction and abuse issues
- Counselling and programs for the children of women with concurrent issues.
- Long term support for women with concurrent issues
- Community safe places for women with concurrent issues
- Better service access (evenings/ weekend hours, transportation, childcare, wait lists, poverty related barriers)
- A common understanding and approach to women across the service system
- Common screening and assessment processes across the service system
- Case management and a case worker who stays with the woman as she moves across services
- Some providers are not part of the service system at all (doctors, private counsellors, other)
- Coordinated strategies to address stigma around mental health, addiction and abuse issues in the community

3. System and Service Coordination

Service providers and women were asked about their experience of system and service

The service provider perspective

Seventy percent (70%) of service providers rated the current level of collaboration between the mental health, addiction and VAW sectors as poor or fair.

Rating	Percentage	Rating	Percentage
Excellent	0	Fair	52
Good	31	Poor	17

The comments from survey respondents give some insight on these findings:

- There seems to be poor communication between the sectors, each group seems to work in isolation. Case conferences rarely occur. More collaboration between agencies would be helpful, even to get to know the other counsellors to put a face to the name/voice.
- Mental health and addiction services are working on Concurrent Disorder Planning however this is not combined with violence against women sector

“There may be opportunities to offer services to women in these areas in different sites, for example, offer service to women in shelters, shared group services.” (Survey Respondent)

- Privacy Act and lack of in-services for caregivers to speak on their services offered and ongoing support offered.
- There is nothing formal in place. It's left to the individual worker to refer.
- The services are separate. The needs of the clients are entwined.
- I think most are just doing what they consider to be their own job.
- People are too busy. There are different service philosophies. Mistrust.
- The lack of coordination is a systemic issue.
- Funding is a pressure for all agencies.

Twenty (20) service providers offered comments on best practices in coordination and collaboration between mental health, addiction and VAW sectors. A summary of these comments appears in the following section the Need for Change.

"The court system seems to think that counselling or treatment (30 days, 60 days, 90 days) will heal the woman right away. Little do they know that the woman could have a history of intergenerational abuse."
(Survey Respondent)

Coordination with the Justice and Child Welfare Systems

Service Providers said that the justice and CAS response to women with concurrent issues was varied, and at times depended on the person (judge, worker) involved in the case.

Justice response:

Twenty-five (25) service providers responded to the question:

"If you have worked with women with concurrent issues who are also involved with the justice system (family, criminal court), how is a woman's recovery (counselling, treatment) viewed by the court system?"

"The legal system confirmed what my abuser told me – you can do nothing – you are crazy." (Interview Participant)

Their answers indicated that justice response to women receiving counselling is varied: it can be positive and beneficial where the woman's treatment is used to show that she is doing something to address her issues, or it can be problematic and be used to show that she is not a reliable witness, a good mother, or she is not competent. Some providers said that there have been improvements within the court system because some judges are aware and sensitive, and because of the court support program. Some specific issues identified include: When a woman seeks counselling and is involved in court her information may no longer be private and subject to subpoena, which may make her reluctant to seek counselling, and the courts may have unrealistic ideas about what women can achieve with short term counselling.

"I have seen very different views from different CAS workers concerning recovery....I find that sometimes CAS expects faster recovery than is possible concerning the stage of change the woman is in, and the availability of services."
(Survey Respondent)

CAS response:

Twenty-eight (28) providers responded to the question:

“If you have worked with women with concurrent issues who are also involved with the Child Welfare system, how is a woman’s recovery (counselling, treatment) viewed by the CAS system?”

The survey responses indicate that there are varied outcomes for women with concurrent issues who are involved with the CAS. Some providers said the way the CAS views the woman’s recovery was unpredictable and dependent on the worker involved. They noted that some workers view the woman’s recovery positively as a sign of taking responsibility, and that CAS is helpful trying to coordinate treatment/counselling services. Some problem areas that were noted: CAS imposing treatment that doesn’t fit with the woman’s readiness, goals, or resources; multiple CAS referrals to services with no coordination; a lack of understanding of the woman’s cultural/ethnic background, for example residential schools; expectations of recovery that are not realistic; and women may be confused about what they need to do.

‘The system is a maze.’ Women’s experience of sector and service coordination

Focus group participants had important things to say about service coordination, or more accurately, the lack of service coordination between sectors. Many women described services as a maze. They emphasized again and again that when they experienced service coordination, it was helpful.

“You go to the psychiatrist, the counsellor, the social worker, the naturopath – and only you pull it together. They don’t care what others are doing.”
(Focus Group Participant)

Women with concurrent issues said that most of the services they used were aware of each other, and communicated with one another, but they were not coordinated. There were some sectors or services that were outside of the loop. The most frequently noted services were family physicians, psychiatrists, Alcoholics Anonymous, private counsellors, and Children’s Mental Health Services.

What emerged from the focus groups was a pattern of referral, from one service to another, where women experienced a sequential or parallel experience of service without connection or coordination. The woman herself was in the position of trying to coordinate services; a task that many women said was impossible.

“My psychologist and therapist rarely talk to one another and usually only for insurance reasons. When they do talk they rarely agree.”
(Focus Group Participant)

Women said that efforts to coordinate services were hurt by:

- Services that compete and disagree

- Service silos
- Staff turnover
- Not including the perspective of women in service delivery
- Too many services at one time (service overload for the woman)
- Duplication of services

They would like to see a service coordination model that includes:

- A “whole picture” approach that addresses all of their issues
- Good communication between providers
- Common screening and evaluation procedures
- Knowledgeable providers who can respond to mental health, addiction and abuse issues.
- A person or service that acts as an ‘anchor’ for women over the long term as she makes improvements and change in her life.
- An integrated approach to service delivery

4. The Need for Change

Focus group participants, survey respondents and the literature articulated a largely congruent need for change in the way sectors and services respond to women with concurrent issues. The following summary statements set out the areas for change and principles from the perspective of women and providers. It is followed by a set of principles for positive change developed as part of a five-year study on the interrelation between violence, trauma, and co-occurring mental health and substance abuse disorders from the literature.

There are challenges associated with developing trauma-specific and trauma informed services: conflicting philosophies, resistance at the service and administrative levels, limited resources, maintaining consistent participation in trauma groups, staff turnover, and change is difficult. (Moses et al., 2003)

Seven areas for change identified by women

Women identified seven important changes for an improved service delivery:

1. *Identify abuse issues sooner.* Provide more information for women about abuse, the impact of abuse and its connection to mental health and addiction issues. Train providers to identify past and current abuse, the impact of current and past abuse on a woman’s help seeking behaviours, safety issues for abused women (including how abusers continue to control women), and the connection between past and current abuse and her mental health and addiction issues. Provide earlier interventions to address childhood and current abuse issues (proactive instead of reactive response).

“ A lot of people in the system don’t recognize the signs of abuse. They see it as a dysfunctional family” (Focus Group Participant)

2. *Educate doctors and psychiatrists* about abuse, the impact of abuse on mental health, community services and supports, proper use of medications with women with current and/or past abuse/trauma issues, the doctor's role in service coordination.
3. Provide *services that equip women with tools, skills, options*, where she can gain control of her life.
4. *Coordinate community services and develop an integrated service delivery model* for women with abuse, mental health and addiction issues.
5. *Change community attitudes that stigmatize* and isolate women with abuse, mental health and addiction issues. Provide information to professionals, families, and friends on how to support women and children in a positive way.
6. Make *changes in the legal system* (criminal and family court) so abusers cannot manipulate, control and intimidate women with mental health and addiction issues.
7. *Improve services and supports for children* who witness abuse and parenting supports for women dealing with abuse, mental health and addiction issues.

"There is still lots of 'victim blaming'. Victims should not be blamed for what happened to them as children, or in their lives, or for their mental illness." (Focus Group Participant)

Eight Areas for Change Identified by Service Providers

Service Providers identified 8 changes to improve service collaboration and the delivery of services for women with concurrent issues:

1. *Intersector training* on: trauma and the link to mental health and addictions, effective screening, assessment, treatment and support approaches, working together, integrated service delivery.
2. Develop *formal sector collaboration, partnerships and strategies* to address service gaps and barriers to service
3. Create *networking opportunities* to share information and expertise
4. Implement *case coordination* across sectors and services
5. Develop *protocol agreements* to support strong relationships
6. Implement formal *sector collaboration to address service barriers*
7. *Include Aboriginal healing approaches* and best practices

"Part of the resistance seems to be turf issues – the medical model versus holistic or woman-centred approaches." (Survey Participant)

8. Develop *integrated delivery of service* (for example services work together to provide groups, services co-located)

Seven Guiding Principles for Positive Change

The 5-year WCDV (Women, Co-Occurring Disorders & Violence) study^x in the United States provides compelling information about the interrelation between violence, trauma, and co-occurring mental health and substance abuse disorders. The study provides recommendations for “trauma-integrated services counselling,” and led to the development of guiding principles for positive change. These principles are relevant for Grey and Bruce and can be used to support community strategies for change:

- Service providers must better *recognize the presence of trauma*, past and present, as a central concern in a woman's life.
- *Women should be encouraged to play an active role in goal-setting* for their services plan and to develop their capacity for self-directed healing, and that they will benefit from a better understanding of how to do so, from the onset.
- *Symptoms are adaptations to traumatic events*—a means by which survivors seek to manage the negative emotional and psychological experiences precipitated by trauma using whatever “self-soothing” means that are available to them at the time.
- *Providers must understand how trauma is triggered* and how to help women create strength-based safe “spaces” in which women can manage their symptoms.
- *Providers should be mindful of the ways in which their own practices and policies might put women in danger*, physically and emotionally, or bring about re-traumatization.
- There must be a more widespread and comprehensive recognition that *violence and trauma significantly impact a person's belief system, self-perception, and relationship with others*.
- Providers need to *meet women where they “are” mentally and emotionally*, with careful readiness assessments, pacing, and a long-term perspective.

::: Community Strategies & Priorities for Action :::

Phase three of this project engaged women who participated in focus groups and interviews and service providers in two community workshops to review the findings from the research (Phase 1 and 2) in order to develop community strategies and action plans.

This phase of the project used a community development approach to:

- Bring together diverse people who share an interest in improving the service response for women with concurrent issues
- Create opportunities for sharing knowledge and perspectives
- Build relationships between the people who use community services because of concurrent issues and the people who provide services
- Build relationships between service providers from diverse sectors, services and communities in Grey and Bruce
- Create opportunities for learning about the experience of women with concurrent issues and models for integrated service delivery
- Create opportunities for women and service providers to develop strategies to improve service coordination and address service gaps in Grey and Bruce

The workshops were designed to facilitate networking, dialogue, learning and consensus building.

Recommendations from the Community Strategies Workshop

On April 18, 2008 the Community Strategies Workshop took place. Eleven women from the focus groups who indicated interest in attending the workshop, and eleven community service providers (community and hospital based mental health, addiction services, VAW services, sexual assault services, physician, CAS, private counsellor) attended the workshop. It began with a presentation on key findings from the Literature Review and the consultation with women and service providers.

The main part of the workshop was organized as a World Café, a facilitated process that engages people in a ‘conversation that matters’ in order to:

- Create communities that work for all of us
- Bring the wisdom of many voices together
- Have a meaningful conversation about strategies to improve service for women
- Call forth what has heart and meaning for each of us

Participants were asked to focus their attention on: what works, what brings life and vitality to an experience and keeps it going, meaningful exchange, cross pollination of ideas, and possibility thinking.

‘The World Café process reawakens our deep memory of two fundamental beliefs about human life. First we as humans want to talk together about things that matter to us. In fact, this is what gives satisfaction and meaning to life. Second, as we talk together we are able to access a greater wisdom that is found only in collective.’
(Margaret Wheatley)

The participants worked in diverse and changing small groups to discuss the following questions:

1. Why is it important for me to be at this strategies workshop?
2. What would help me get 'out of the box' and move towards an understanding of the whole picture?
3. What stands in the way of a more holistic way of understanding these issues? What would it take to respond differently?
4. What does working together look like? Who is included? How do we make it happen?
5. What are our priorities for change for our community and us?

"Healing happens in community"
(Workshop participant)

At the end of the workshop, nineteen (19) Community Strategies were developed, along with a ranking of priorities for action.

The Community Strategies Workshop was an intense and meaningful meeting of people who want to see a more coordinated and effective service response. The World Café format encouraged a 'levelling of the playing field' for consumers and providers. In fact, one of the most compelling findings from the day was that providers of service deal with mental health, addiction, and abuse issues themselves, or in their families. This is not just a client issue, and this realization decreased the tradition 'gap' between provider and consumer, and helped to foster change.

"We are too isolated. We need to connect and establish relationships"
(Workshop Participant)

There was a formal evaluation of the workshop, completed by 20 of the 22 participants. All aspects of the workshop were very positively rated.

Comments included: "Talking, sharing with other women who are in my shoes – an awesome day of knowledge sharing with other women", "All good-excellent format", "It was good to hear women's voices." "Bringing together consumers and providers – it was a perfect beginning – just let it snowball."

The Community Strategies listed below were the first attempt at consolidating the findings from the research into action items. In addition, participants recommended: ***Get together in a year to see how we have done in our community on these strategies, and where we are going. Monitor progress on strategies quarterly.***

Community Strategies	Ranking
Address women's isolation with a safe place where services are connected in one location . (Building women's community, a place for women to meet and share, access to information, interdisciplinary groups, counsellors, on site childcare, shared transportation network.	1
Services/supports in all sectors need to include three steps for women : help to name the issues, find their voice, and build self-esteem and maintain hope.	2
Use an integrated approach to educate our children about mental health, addictions and abuse.	3
Single point access with 1-800 number . Telehelp that forwards woman to a case worker who stays with the woman while she uses services	4
Address stigma for women getting help by recognizing that providers and users share many of the same issues – seek commonalities that exist between service users and providers to address stigma. Develop tools to address stigma that people help talk about these issues, learn from each other, take courage, develop community	5
DBT (Dialectic Behaviour Therapy) and Employment Assistance are two models that are working and are needed for all women	5
Get men involved in these issues so men can “get real” and get involved	6
Intersector training and education is needed for providers on types of abuse, impact of abuse, how to talk to women about abuse issues, to challenge their belief systems and the status quo, and on intersector collaboration.	6

Community Strategies	Ranking
VAW services could provide a drop in space for women in crisis because of concurrent issues to prevent women going to the hospital, to monitor meds, for crisis intervention. A place where women can get help without the stigma of the hospital and labels.	6
Stop building silos in ourselves and with services. Create change in our communities by taking small steps towards a more holistic approach. Throw out the boxes and the idea that there are experts. See this as a community problem and eliminate all the hoops for women. Need to look at the 'root' of these problems and the many connections between the issues.	7
Important to have a female police officer or female victim services support for women to help women deal with their fear of power and control, and to help her understand issues and reduce her isolation. Police need to take more action to protect women	8
Ensure that information is available for women on all issues and how they intersect. Include information on dealing with stigma and how stigma is connected to these issues	9
Need more appropriate information and support for teens dealing with concurrent issues – many more teens struggling with mental health, addictions, abuse issues. (Puppets are great)	10
Women who are involved in the system need to have a leadership role in system decision making – not tokens. Women need access to their information.	11
Doctors need to be involved in integrating and coordinating work and involving women in their healing (provide reports, information, woman is fully informed)	12
Women need to educate themselves on their rights	13
Services stop “owning” the woman. Need a model where the woman is in charge of her healing and where services are not based on her label	14
Make a long term plan for system change and identify the potential roadblocks and strategies to avoid getting bogged down.	15
Community members need to know one another better so they are comfortable and connect – organize networking opportunities (extend this to include boards of directors from organizations to create an integrated response)	15

::: Recommendations from the No Wrong Door Workshop :::

No Wrong Doors was an all day workshop on June 10th with 62 participants representing service users and community service providers working with women dealing with mental health, addictions and abuse issues. The day began with presentations from Susan Macphail, Sarah Hilton and Sandra-Lynn Coulter from the Women's Mental Health and Addictions Research Coalition in London Ontario on the work they have done to integrate services for women with concurrent issues. It included information on the implementation of a common screening tool in London, an integrated group model called TRIPOD, and an integrated approach to service for hard to serve women with concurrent issues at My Sister's Place. In the afternoon the results of the Grey Bruce research and Community Strategies workshop was presented. Workshop participants worked in small, diverse groups to develop a list of priorities for action and action plans for a more coordinated and integrated response for women with concurrent issues.

"The small group discussions were a great sharing opportunity"
"A powerful presentation"
"What was helpful is knowing there is a solution out there – let's implement it, it's a no brainer!"
(Comments from Workshop Evaluations)

The No Wrong Door Workshop successfully brought together people with a broad range of perspectives to learn and develop community action plans together. There was a formal evaluation of the workshop. Participants rated the day very positively (overall satisfaction with the day was rated 3.6 on a scale where 1 is poor 2 is fair, 3 is good and 4 is excellent).

The following is a report from the No Wrong Door Workshop on readiness for change and action items.

Readiness for Change:

Workshop participants overwhelmingly support making system and service changes to integrate service delivery and to improve service coordination between mental health, addictions, and violence against women services. In addition, key sectors such as CAS, police, probation, health care providers and First Nations services need to be part of a coordinated response.

Priority Areas for Change:

Participants identified six key areas of work:

- Women of Experience Steer the Process
- Improved Sector Collaboration
- Formal Protocols across Sectors
- Common Screening and Assessment Tools
- Intersector Communication and Case Coordination
- Joint Training

1. Women of Experience Steer the Process of Change

Women who use services are the reason for the service and must have a primary role in community coordination and integration work to make services more helpful and effective.

“Let the women of experience lead the process. They are the experts in their own life situation. Hear what they say!” (Workshop Participant)

Service sectors and providers must carefully think about the important role of women and make legitimate space for women of experience to exercise their role.

Recommendations for actions include:

- Provide women with information and opportunities for engagement
- Clarify values within organizations to support women's involvement
- Build knowledge and leadership with women
- Engage women and providers in dialogue for change
- Evaluate where we are and where we need to go

2. Intersector Collaboration

Intersector collaboration is needed to bridge sectors that have diverse mandates, philosophies and funding parameters. System and service collaboration is needed and will require some changes in the way sectors and providers work.

Action Items for Systems Collaboration include:

- A working collaboration between mental health, addictions, VAW, health, justice and child welfare is necessary and will require support from sector planning bodies (LHIN, provincial associations, provincial funders).
- Shared funding to support specific collaborative activities such as transportation, volunteer supports, information and education activities, and joint training initiatives.
- Shared space that would support an integrated service response in one location
- Education and engagement of all sectors, including health services and family practitioners.

Action Items for Service Collaboration include:

- An intersector case management approach that supports women over many years of service, and that is based on a client centred and trauma informed approach.

3. Formal Protocols

We need formal protocols between sectors and services that detail how service coordination and intersector collaboration happens. Women of experience have an important role to play in the development of these protocols. There is currently a broad intersector protocol in place that supports a community response to abuse that could be used as a starting point.

The formal protocol should include:

- Common mission and goals
- Partnering agreements between services
- Training – mandatory training for all sectors and training plans
- Collaboration agreements
- Service access agreements

Some potential barriers that will need to be addressed in protocol work include:

- Legislation and mandates governing sector work
- Time and funding required for protocol development, implementation and training
- Motivation by key sectors to formally enter into agreements

4. Common Screening and Assessment Tools

The morning presentation on a common screening and assessment tool that is in place in London was instructional and highlighted the benefits and effectiveness for women and for providers when common approaches to screening and assessment are in place. Participants at the workshop supported the idea of developing a common tool that would work across sectors and that would include:

- Common tools
- Make screening by telephone possible
- Eliminate duplication for women
- Focus on building relationship with women
- Consideration of the woman's right to privacy and to chose when she discloses information
- Uses clear language that works for women and providers in all sectors
- The development of the screening tool would include women
- Includes a flow chart that helps providers and women know the next steps following screening and assessment.

Action Items for Common Screening and Assessment Tools

- Partner with Women's Mental Health and Addictions Action Research Coalition for pilot project to implement the London screening tool.

5. Intersector Communication and Intersector Case Coordination

Women with concurrent issues use many services over long periods of time, and face both internal and external barriers to service (difficulty identifying their issues, trust issues, fear of authority, poverty, lack of transportation, control by their abuser, parenting issues). They need providers with a high level of communication and coordination who act as case managers across sectors as they deal with their complex needs and issues. Information sharing, networking and case management strategies will improve service delivery for women.

Action items for intersector communication and case co-ordination:

- Information sessions on what and how community agencies provide services (for providers and consumers), for example through lunchtime networking sessions.
- Shared video conferencing (need to develop this capacity and address access)
- Establish a listserv to exchange information and resources, and post information on a central community website (for example: www.endabusenow.ca)
- Provide information for women on how their information is shared, how the system works, where they can access information
- Designate people within in each agency who act as contacts for information and consultation on concurrent issues.

6. Joint Training

Many more service providers in key sectors need the training, networking and information sharing opportunities that were presented at the workshop. There is a need for a repeat of the No Wrong Doors workshop format for all providers in mental health, addictions and VAW sectors, as well as providers in the child welfare, justice and health care sectors.

Action items for joint training include:

- Intersector training for front line staff on early identification, screening, asking questions, responding to disclosures (what to do when you find

out), specific training on addictions, mental health, abuse and the impact of abuse, and child protection.

- Intersector management training on intersector collaboration; trauma informed service delivery, new directions for rural communities, building shared values and service goals for collaborative work.
- Intersector training needs to include face-to-face opportunities for networking and relationship building for staff from various sectors.
- On line training opportunities on a website that can be accessed by all (for example: www.endabusenow.ca)

::: Next Steps :::

The research findings and recommendations from the Community Strategies workshop and No Wrong Door workshop provide the basis for a community plan to improve service coordination and to address gaps in service for women with concurrent issues in Grey and Bruce. Participants from a broad range of community agencies and sectors at the No Wrong Door workshop endorsed moving forward with five priority action items.

The next steps in this process include:

1. Distribution of this report to community stakeholders, regional and provincial planning bodies, and provincial funding bodies.
2. Presentation of the key findings and action items to the Grey Bruce Violence Prevention Coordinating Committee with the recommendation that GBVPCC support the development of a short and longer-term implementation plan for the action items outlined in this report. The GBVPCC has already committed funding for an intersector training event in 2008-2009 to enhance collaboration between mental health, addictions and VAW services.
3. Presentation of the key findings and recommended action items to the Grey Bruce Concurrent Disorders Working Group and the Grey Bruce Mental Health and Addictions Network to look at ways to include the results of this study in planned training for mental health and addictions workers in Grey and Bruce.
4. Presentation of the key findings and action items to the senior managers of Mental Health Grey Bruce partnership for support for the development of a short and longer-term implementation plan for the action items in this report.
5. Presentation of the key findings and action items to Local Health Integration Network, southwest region, for support for the development of an implementation plan.

6. Prepare a funding proposal to Status of Women Canada to develop leadership for women who have used services and wish to take an active role in improving service coordination in Grey and Bruce.
7. Support the implementation of common screening tools for addiction, mental health and abuse issues by: pursuing involvement with a province wide initiative to develop and implement a common abuse screening tool, and coordinating abuse screening with screening and assessment initiatives underway in the mental health and addiction sectors.
8. Investigate other sources of provincial and federal funding to further develop and implement the recommendations from this report.
9. Develop a planning process that establishes a group with provider and service user representation, supported by leadership, to complete a system review and change plan based on the recommendations of this report, and that complements current collaboration initiatives in Grey and Bruce.

::: Conclusion :::

The Rural Strategies for Women with Abuse, Mental Health and Addiction Issues project successfully engaged women who use services because of concurrent issues and providers from a broad range of community services in Grey and Bruce in a research and community development process. The project has generated new information from the perspective of both consumers and providers of service in this rural community about how women seek help for concurrent issues, how community services respond, and the current status of service and system coordination in Grey and Bruce. Community stakeholders were involved in a review of the findings from current literature and the community research and in the development of community strategies and priorities for action. The research and community development process was largely a positive and hopeful exercise that points to many opportunities for change that all participants believe is critical for our rural community.

There is a great need for a change in the way the mental health, addictions, VAW and other community sectors and services provide respond to women who are vulnerable and most in need of an informed comprehensive and coordinated delivery of service. Women said they need a delivery of service that is trauma informed and helps them identify and get help for the many complex issues in their lives. They need and deserve a collaborative community service response where there is No Wrong Door.

::: Appendix :::

Appendix 1 Mental Health, Addictions and Abuse Advisory Committee

Anna van den Hogen	Women's House Serving Bruce and Grey
Claude Anderson	Canadian Mental Health Association Grey Bruce
Cheryl Bruce	Consumer
Carol Moore	The Women's Centre (Grey & Bruce)
Paul Wagler	Withdrawal Management Services (GBHS)
Kent Smith	Probation
Jill McArthur	New Directions for Alcohol, Drugs and Gambling
Melissa Weber	Consumer
Wendy Margetts	Partner Abuse and Sexual Assault Care Centre (GBHS)
Candace Burton	Women's House Serving Bruce and Grey
Connie McKay	D'binooshnowin Crisis Centre

Appendix 2 Literature Review

Rural Strategies for Victims of Woman Abuse with Mental Health and Addiction Issues

Literature Review

*Prepared for Colleen Purdon, Coordinator
Grey Bruce Domestic Violence Coordinating Committee*

Julia Ostertag

Scope of the Review

This literature review focuses on the integration of services for victims of woman abuse with mental health and addiction issues in a rural setting. The literature review was conducted by focusing primarily on recent Canadian literature; however, research from the United States (Women, Co-Occurring Disorders and Violence Study), and England (the Stella Project) were also included for their pioneering contributions to this relatively new field of study.

Accessibility of Literature

Literature based on research in Ontario comes primarily from Carol Kauppi and Denise McKinlay's 2005 report *Bridging the Service Gap for Sexual Assault and Mental Illness Survivors* (Sexual Assault Survivors' Centre Sarnia-Lambton) and the London-Middlesex area through the work of the **Women's Mental Health Addiction Action and Research Coalition** (Thielen-Wilson and Hinton's 2001 report, *Phase One: Barriers to the Implementation of Gender Sensitive Policy & Principles of Service in Ontario's Mental Health System* and Hinton's 2002 (Phase Two) *Kitchen Table Project: Evaluating the Experiences of Women within the Mental Health System Reform*). There is very little focus on rural women's issues in this literature, although the Kitchen Table Project recognizes isolation and abuse as central concerns for women within the mental health system. The results of May Tetters's two-year study of rural women who experience abuse and their help seeking provides important insights into the issues particular to rural women in Grey/Bruce counties in south western Ontario (Tettero, 2008).

The **Centres of Excellence for Women's Health** are an excellent source of literature on women's health (including addictions and mental health problems). Increasingly, their publications, information sheets, and community discussions link women's health issues to violence against

women. The British Columbia Centre of Excellence has an ongoing community learning initiative titled “**Coalescing on Women and Substance Use**” that has resulted in publications and useful briefing notes on women and abuse, mental health, and substance use. The Prairie Women’s Health Centre of Excellence has a greater focus on rural women’s issues (see the Reports *Rural and Remote and Northern Women’s Health: Policy and Research Directions* and *Rural and Remote Women and the Kirby-Keon Report on Mental Health: A Preliminary Gender-Place Analysis*.)

Research conducted by the Centres of Excellence for Women’s Health is gender, place, and culture based. As a result, their recommendations focus on factoring gender, place, and culture into health care policy. Similarly, Thielen-Wilson and Hinton’s 2001 report, *Phase One: Barriers to the Implementation of Gender Sensitive Policy & Principles of Service in Ontario’s Mental Health System*, emphasizes that gender sensitive principles and policies are a necessary prerequisite to meet women’s unique needs within the mental health system. Key findings from this report also point toward unaddressed links between violence and mental health, as well as women’s experiences of isolation due to stigma and physical location. *Phase Two: The Kitchen Table Project* led to an expansion of Routine Universal Comprehensive Screening for woman abuse (RUCS) to the mental health and addictions sectors through the publication of a screening protocol: *Implementing a Woman Abuse Screening Protocol: Facilitating Connections between Mental Health, Addictions and Woman Abuse* (MacQuarrie, 2007) and the publication of *TripodPROJECT: A Facilitator’s Guide* (Coulter & Harold, 2007). Both phases of the research and the screening protocol reflect the Women’s Mental Health and Addictions Action Research Coalition’s commitment to relational-cultural theory, an approach developed by Jean Baker Miller (1976) and the need for integrated approaches to providing mental health, addictions, and woman abuse services.

Important work on integrated services for women with mental health problems, substance use and histories of violence comes out of the United States through the **Women, Co-Occurring Disorders and Violence Study** (WCDVS), sponsored by SAMHSA (Substance Abuse and Mental Health Services Administration) (http://mentalhealth.samhsa.gov/nctic/sponsored_initiatives.asp#women). WCDVS grew from the increasing realization by mental health and substance abuse service providers that most of the women in their systems had long-standing histories of physical and/or sexual abuse.

Key Messages

The link between women’s experiences of physical or sexual abuse and addictions and/or mental health problems is well documented in the

literature. Up to three quarters of women with severe mental illnesses report a history of sexual coercion as many as two thirds of women with substance use problems report a concurrent mental health problem such as post-traumatic stress disorder, anxiety, depression. In addition, many of these women also report surviving physical and sexual abuse (National Center on Addiction and Substance Abuse, 2003). For instance, in London-Middlesex an addictions services agency reported that 80 percent of women screened at assessment disclosed experiences of abuse (MacQuarrie, 2007). Increasingly, service providers are recognizing that women with histories of trauma and co-occurring disorders (substance use and mental health problems) require integrated, trauma-informed treatment. This approach is informed by research into the effects of post-traumatic stress disorder, and has resulted in specific group facilitation trauma recovery approaches such as TREM and ATRIUM.

The SAMHSA Women, Co-Occurring Disorders and Violence Study, conducted on nine sites across the United States, required that each site implement one of four group-based trauma-specific treatments. These approaches are listed in McHugo et al.'s 2005 article:

1. **Trauma Recovery and Empowerment Model (TREM)**. This model is based on psycho-educational, cognitive behavioural, and skills-building approaches aimed at women with mental health problems and histories of sexual and physical violence. (Fallot and Harris, 2002; Harris, 1998)
2. **Seeking Safety** Curriculum is explicitly cognitive behavioural and targets women with PTSD (post-traumatic stress disorder) and substance use (Najavits, 2001)
3. **Addiction and Trauma Recovery Model (ATRIUM)** is holistic and explores the mind/body interface (Miller and Guidry, 2001)
4. **Triad Group Model** approach develops mindfulness, interpersonal skills, emotions regulation, distress tolerance (Clark and Fearday, 2001)

The BCCEWH webcast *Working with women on violence-related and substance use issues: The role of anti-violence services* also listed Seeking Safety and TREM as models for trauma-informed approaches to providing integrated services.

The **Stella Project** in the UK provides an excellent toolkit for both domestic violence and substance use service providers. It also includes tools for service providers dealing with perpetrators who also have substance use problems. The toolkit offers some basic advice for workers dealing with dual diagnosis (mental health and substance use) clients. The primary focus is on inter-agency collaboration and acquiring a basic understanding of mental health issues (problems of misdiagnosis with substance use, holistic

understanding of health, etc.). The toolkit is available online at http://www.womensaid.org.uk/landing_page.asp?section=000100010010000400020004.

In Ontario, the Trillium Foundation provided \$25,000 over 8 months to finalize a pilot project which introduces an abuse-screening protocol to front-line mental health and addiction service providers. The **Women's Mental Health and Addiction Action and Research Coalition**, under the Canadian Mental Health Association, London-Middlesex Branch, conducted this project in 2005-2006 (Coulter & Harold, 2007; MacQuarries, 2007). According to a recent Ontario survey by the Women's Mental Health and Addiction Action and Research Coalition, "85% of women with mental health or substance use problems had experienced physical, sexual or emotional abuse" (Buttery, 2003). The problem, however, is that "abuse is frequently missed by health care providers because they are trained to fix symptoms, not the root of a problem" (**Susan Macphail**, executive director of LECMHS, London East Community Mental Health Services). Through this project, front-line staff in London-Middlesex has been trained to use the **RUCS** (Routine Universal Comprehensive Screening) protocol. According to **Bonnie Williams**, programs manager of the London-Middlesex branch of Mental Health Services of the CMHA, RUCS reflects an attitude shift in the medical profession, and will hopefully eliminate the social taboo of talking about abuse.

Although there is a dearth of literature regarding integrated, coordinated services in **rural communities**, existing research indicates that rural settings face unique challenges. Primarily, the research focuses on the **lack of transportation and childcare services as barriers to women's participation**, though anonymity and stigma were also cited as concerns. In a study conducted at 13 sites in BC, *Connecting Systems, Supporting Change: Transition Houses, Women Experiencing Partner Violence and Substance Use*, participants indicated that they had difficulties navigating the health and social services systems because these systems and services are not coordinated to deal with multiple issues. This was particularly true for rural women who were more likely than urban women to have difficulties accessing services. In Morrow and Chappell's 1999 report, *Hearing Voices*, barriers for rural women with mental health problems included having access to housing, accessing services (particularly for women from diverse cultural backgrounds), and fewer services such as drop-ins, clubhouses, or supported independent living environments – which disproportionately serve men (Morrow and Chappell, 1999, 28). However, on a more positive note, it was also felt that because rural communities are smaller, more coordinated responses between service providers are possible.

From a study conducted in Sarnia-Lambton, *Bridging the Service Gap for Sexual Assault and Mental Illness Survivors*, the following strengths, weaknesses, barriers, and recommendations were developed for concurrent mental health and abuse services in their primarily rural and semi-urban region (Kauppi, Carol and Denise McKinlay, 2005):

Strengths of Existing Services

- A wide range of programmes is available to address the practical needs, crisis needs, support systems and social needs for the SMI (severe mental illness) population.
- Professional skills and knowledge of service providers.
- Service participants' strategies and abilities to access services.

Problems with Existing Services

- Service delivery: limited publicly funded counselling services, long waiting lists, programme cuts, limiting criteria for services, fee for service, difficulty in gaining admission to psychiatric ward at hospital, poor coordination of services.
- Service providers: little counselling available from psychiatrists, lack of understanding and sensitivity to issues surrounding sexual abuse/assault and mental illness, poor knowledge of community resources, deficient counselling skills and personal qualities that were perceived as judgmental and officious, sexual misconduct by service providers.

Barriers to Existing Services

- "Red tape", confusing paper work and inability to meet criteria for service
- Practical barriers: lack of transportation, telephone, childcare, inability to access services during regular office hours, fee for services.
- Service participants' compromised abilities: poor communication skills, being hampered by symptoms of mental illness, feeling fearful, issues related to age.
- Stigma: internalizing stigma, the public's fears, service providers' attitudes towards people with mental illness, service providers poorly trained to handle the issues.
- Community concerns: inadequate housing and an increased risk to personal safety.
- Lack of family support or active interference by family members.

Barriers to Reporting to Police

- Attitudes of legal professionals: myths and stereotypes.

- Fear of: reprisals by perpetrator, rejection by family/peers, public shaming, being blamed for the assault, breaking the “code” of the streets, retelling the story.
- A perception of revictimization by court process.

Gaps in Services

- Formal and informal support systems.
- Advocacy services: professional and peer advocacy.
- Therapeutic programmes: communication and social skill building, relationships, educational, cognitive-behavioural groups, trauma programmes, groups for family members, psycho-educational groups.
- Further services required: youth programmes, practical skills (budgeting), peer partnering programmes, eating disorder programmes, services for men.
- Residential programmes: treatment focus (addiction, detoxification, sexual abuse, trauma), shelter (formal shelter system).

Participants’ Recommendations for Change

- Community collaboration: case management system, collaboration with medical community, formal networking process, community resource manual.
- Coordination of programmes for volunteer service participants: resources, media interviews, school programmes, public education.
- Education, awareness and training for public, professionals and service participants.
- Government and legislative changes: increase funding to organizations and agencies, increase minimum wages, increase Disability and Ontario Works income, invest in adequate low-income housing
- Developing and implementing programmes at the community and organizational level: outreach programmes, advocacy, formal and informal support systems, therapeutic programme

These strengths, weaknesses and barriers in the Sarnia-Lambton region may be similar to those found in Grey and Bruce counties due to their similar populations. However, no specific mention is made of barriers that may result due to rural populations. One of the outcomes of the three-year *Bridging the Service Gap* project was the development of the In-Service Cross-Training Initiative (ICTI) (McKinlay & Kauppi, 2007).

The 5-year WCDV (Women, Co-Occurring Disorders & Violence) study provides compelling information about the interrelation between violence, trauma, and co-occurring mental health and substance abuse disorders. The

study provides recommendations for “trauma-integrated services counselling,” and led to the development of guiding principles for positive change:

- Service providers must better recognize the presence of trauma, past and present, as a central concern in a woman's life.
- Women should be encouraged to play an active role in goal-setting for their services plan and to develop their capacity for self-directed healing, and that they will benefit from a better understanding of how to do so, from the onset.
- Symptoms are adaptations to traumatic events—a means by which survivors seek to manage the negative emotional and psychological experiences precipitated by trauma using whatever “self-soothing” means that are available to them at the time.
- Providers must understand how trauma is triggered and how to help women create strength-based safe “spaces” in which women can manage their symptoms.
- Providers should be mindful of the ways in which their own practices and policies might put women in danger, physically and emotionally, or bring about re-traumatization.
- There must be a more widespread and comprehensive recognition that violence and trauma significantly impact a person's belief system, self-perception, and relationship with others.
- Providers need to meet women where they “are” mentally and emotionally, with careful readiness assessments, pacing, and a long-term perspective.

Also identified through the WCDVS were challenges associated with developing trauma-specific and trauma informed services (Moses et al., 2003):

Conflicting philosophies

- Addictions treatment is considered confrontational, whereas mental health services are based on bio-psychiatric and/or case management support model
- Anti-violence work is from a feminist perspective

Resistance at service level

- All sites initially encountered resistance, hesitation and concern
- Concern that a trauma-informed approach would be “opening Pandora’s box”
- Workers felt unqualified to provide “highly specialized” treatment
- Fear that assessing trauma histories would trigger unmanageable symptoms and possibly reduce women’s safety

- Disbelief that trauma was a primary issue for women with co-occurring disorders
- Sequential, not integrated, approach
- Community workers are already tremendously overworked
- Lack of knowledge
- Clinicians' own unresolved trauma issues
- Solution: Sites offered continuing education credits for training

Resistance and the administrative level

- Administrators did not believe that services and systems could be changed without substantial funding
- Limited staffing resources
- Some were supportive, but felt that their organizations were focused on crisis management
- Solution: training, inter-agency planning groups, shared personnel resources

Limited resources

- Already under-funded services
- Difficult to reimburse services
- Limited clinician time

Maintaining consistent participation in trauma groups

- Transportation, child care services
- Transportation is a key barrier for women in **rural communities**
- Participants' hesitation, fear
- Participants' focus on "survival" (housing, etc.)
- **Solution:** provide on-site day care, arrange transportation

Staff turnover

- Constant need to educate and train new staff costs time and money

Change is difficult

- Extra coordination, communication, cooperation, time required

Tensions within the Literature

It appears to be generally well accepted within the literature that services must be increasingly integrated to best serve women who are abused and have co-occurring disorders. Depending on the service provider's treatment approach philosophy, some variance exists, though these are generally seen as complementary differences. The primary concern in BC is with the merger of mental health and addictions services. Most service providers appear to be

recognizing the need, however, that trauma-informed and trauma-specific treatment for women is integral to the treatment approach.

In London-Middlesex, service providers are adopting RUCS, a **universal screening** process for front-line workers to assess histories of violence. However, according to the BCCEWH, universal screening is not effective, and that a conversational approach is more appropriate once trust has been established.

Gaps in Current Research

Integrated services for rural women have not been studied in great depth in Ontario or elsewhere. An upcoming article, that is currently in press, by Jategaonkar, Greaves, McCullough, Poole, and Chabot, ***Multiple Isolation: Concurrent experiences of substance use and violence among women in rural and urban British Columbia*** (Canadian Woman Studies) will likely shed some important light on the issue of rural women's access to integrated services. The work of the Prairie chapter of the Centres of Excellence for Women's Health also delves into rural women's concerns.

Although few studies and projects specifically address integrated services for rural women, a great deal can be gleaned from the various service providers' attempts at integrating addictions, mental health, and abuse services for women. For instance, **Breaking the Cycle** is an early intervention program for pregnant women and mothers dealing with substance use and issues surrounding fetal alcohol syndrome. Central to Breaking the Cycle's approach has been an integrated approach acknowledging the need for consistent, coordinated, collaborative, community-based responses utilizing harm reduction, trauma-informed interventions and cognizant of complex issues such as isolation (social and geographical), abuse, and mental health (Motz et al., 2006; Leslie, 2007).

Research and Policy Directions

Gender, place and cultural lens for all research and policies regarding women and women's health

Research into barriers to services for women in rural communities

Research into trauma-informed services for women with histories of abuse and co-occurring disorders, as this is still a relatively new area of treatment and has not been fully integrated into VAW services, abuse perpetrator services, mental health, and addictions services.

Aboriginal Women

Research into mental health, substance use, and violence against women in an Aboriginal context is necessary considering the high levels of physical and

sexual abuse among Aboriginal women, and the high rates of suicide (Morrow, 1999: 48). According to Morrow and Chappell, mental health services in Aboriginal communities need to recognize the mental health impact of colonialism, the fact that service providers are often perceived to be racist, service provision is transient, and the lack of follow up. Follow up was often limited because service providers were uncertain about passing information to other organizations due to the Freedom of Information Act (e.g. passing information between the hospital and Crisis Centre counsellor). On a positive note, Aboriginal women were least likely to be diagnosed with severe mental illness, in part because they make use of peer support and community building.

Conflicting treatment philosophies

Merging addictions and mental health services in BC has raised a number of concerns. According to the BCCEWH's briefing notes to the Ad Hoc Group on Women, Mental Health, Mental Illness, and Addiction, since addictions and mental health services have merged, the medical approach of mental health services has dominated, at the expense of multifaceted, comprehensive, and women-centred addictions and trauma approaches (BCCEWH, 2006: 17). And, although the services may be provided more efficiently, this merger risks minimizing or obliterating the specific interests of one group of clients or care providers. As a result, Morrow and Chappell's 1999 Report *Hearing Voices* recommends a shift from a bio-medical understanding of mental health to a **bio-psycho-social understanding**.

Recommendations from Morrow and Chappell's report *Hearing Women's Voices* (page 69ff):

- Train mental health workers to recognize women's responses to violence and trauma
- Train feminist anti-violence frontline workers to provide support to women who have mental health problems and are also experiencing abuse
- Provide support for long-term counselling and peer support groups for women
- Implement supportive training programs for mental health care consumers to help them better understand the impact of violence on women and to develop assertiveness skills to keep them safer
- Establish programming that recognizes the interconnection between substance use, mental health problems, and histories of physical and sexual abuse
- Non-punitive policies for dual-diagnosed women
- Amendments to Mental Health Acts in Canada to not discriminate against dual-diagnoses

Conclusion

Presently, there is exists little, if any, focused research into integrated rural services for women with histories of abuse and co-occurring disorders. Studies such as the WCDVS in the United States included rural sites; however, the research findings do not highlight any differences between urban, rural or semi-urban sites. Whenever rural differences are mentioned in the literature, the focus is primarily on barriers to women's participation in integrated services, such as a lack of transportation and childcare. On a positive note, however, mention was made of rural communities' ability to integrate services more effectively than in larger, urban centres.

The link between women's experiences of physical or sexual abuse and addictions and/or mental health problems is well documented in the literature. This points to the need for women-specific programs in mental health and addictions services, which currently disproportionately serve men (although statistically, women access mental health services more than men).

As demonstrated by publications from the Centres of Excellence for Women's Health, a gender, place, and culture lens is necessary when conducting research or developing policies to integrate services dealing with VAW, mental health, and addictions. In addition, the work of the WCDVS integrates recently-developed theories of post-traumatic stress disorder and the need for trauma recovery into models employed at service sites, with improved clinical treatment results and no greater costs to service providers.

Annotated Bibliography

Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addiction. (2006). *Women, Mental Health and Mental Illness and Addiction in Canada: An Overview*.

In anticipation of the Kirby-Keon Report on Mental Health, Mental Illness and Addiction in Canada, the Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addiction prepared information sheets that demonstrate the importance of gender-based analysis in developing health care policies. Two information sheets prepared by the BC Centre of Excellence for Women's Health, *Bridging Women's Experience of Trauma and Violence into Canadian Mental Health and Addiction Policies and Programs* and *Women and Addictions*, are of particular relevance to research on the intersection between women's experiences of abuse and mental health and addictions services.

BCCEWH. (2006). Information Sheet 4: Discussing substance use with women and offering programming that addresses violence, substance use and related health and social issues. *Coalescing on Women and Substance*

Use. Virtual Community Discussion Paper, BC Centre of Excellence for Women's Health. www.womensdirectorate.gov.yk.ca/pdf/infosheet4.pdf

Women who experience violence and trauma are often reluctant to seek services if they also have substance use issues because they fear (1) that anti-violence service providers will turn them away; (2) they feel shame about substance use, fostered by societal stigmas; (3) women fear losing custody of their children if child welfare authorities find out; and (4) being forced into treatment for substance use. It is important to develop safe and respectful ways to discuss substance use, as well as policies to ensure women's safety. These spaces for conversation can be formal or informal (e.g. Stitch and Bitches). It has been found that **Universal Screening for substance use is not effective**. Instead, frontline anti-violence workers should employ a conversational approach after the crisis is over and trust has been established. This approach should recognize the importance of *where a woman is at* in her own healing – if she feels that substance use is helping her to cope, then it is often not useful to focus on making stopping substance use a primary goal or denying her services.

Domino, M.E. et al. (2005). *Service Use and Costs for Women with Co-occurring Mental and Substance Use Disorders and a History of Violence*. Psychiatric Services. October 56(10): 1223-1332.
<http://ps.psychiatryonline.org>

Costs of service use were examined for the 2,026 women who participated in the WCDVS (Women, Co-Occurring Disorders and Violence Study, N=1,018) and in the comparison group (N=1,008). **No differences were detected in the costs, but improvements were seen in the clinical outcomes, which is a good indicator of the efficacy of integrated services.** However, although the WCDV study included rural and urban study sites, no analysis was made on the differences in services and service costs between these areas.

Kauppi, Carol and Denise McKinlay. (2005). *Report on Bridging the Service Gap for Sexual Assault and Mental Illness Survivors*. Sexual Assault Survivors' Centre Sarnia-Lambton.

According to this report, government and service providers have been aware of the gaps in services to victims of abuse who also have mental illnesses; the findings from this research point toward

strengths and problems of existing services, as well as the barriers to and gaps in these services.

Huntington, Nicholas, Dawn Jahn Moses, and Bonita Veysey. (2005). *Developing and Implementing a comprehensive approach to serving women with co-occurring disorders and histories of trauma*. Journal of Community Psychology. Volume 33(4): 395-410. www.interscience.wiley.com

The Substance Abuse and Mental Health Services Administration (SAMHSA) funded the Women, Co-Occurring Disorders and Violence Study to generate empirical knowledge on how to improve services for women who are trauma survivors and have co-occurring mental health and substance use disorders. First, the article contains a literature review on the pervasiveness of trauma among women and the ways in which current service systems fail to address their needs. Second, the article describes the four core principles developed by the nine model grantees (1 rural, 4 urban, 1 semi-rural, 2 mixed (urban, suburban and/or rural) across the US). These principles were tested by the grantees over 5 years, after which they mandated that **services be (a) integrated, (b) trauma-informed, (c) consumer involved, and (d) comprehensive.**

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Morrow, Marina and Monika Chappell. (1999). *Hearing Women's Voices: Mental Health Care for Women*. British Columbia Centre of Excellence for Women's Health. www.bccewh.bc.ca

This report emphasizes the need for a **shift away from a bio-medical understanding of mental health to a bio-psycho-social** understanding of women's mental health. This report looks at barriers to mental health care for women from an integrated perspective, and provides perspectives to shaped the implementation of the BC Mental Health Plan. Research was conducted by an advisory group and focused on stories from women with mental health issues, mental health service providers, and family members, as well as literature reviews. A gender lens was used to analyze findings, which focused on the social determinants of mental health (poverty, housing, stigma). A women-centred mental health care approach was advocated. This focused on issues such as **barriers (page 26: rural barriers include housing and stigma, less services, male-oriented services)**; trauma, violence and mental health (page 33); substance use and mental health (page 40); Aboriginal women (page 48); and best practices for meeting the needs of women in the mental health care system (page 68).

Morrow, Marina. (2002). Violence and Trauma in the lives of women with severe mental illness: Current practices in service provision in British Columbia. BCCEWH. www.bccewh.bc.ca

The report documents the practices of five mental health service providers with respect to provision of services to women with chronic and persistent mental health problems who are survivors of violence. The key messages of the report are that: **mental health programming and planning do not systematically attend to the social determinants of mental health; gender analysis and a shift to a bio-psycho-social paradigm are necessary;** diagnosis problems lead to reduced services for women (many mental health service providers are mandated to work primarily with SMI (or Axis I diagnoses). Women with histories of trauma are often – incorrectly – diagnosed as Axis II); absence of support services and housing; and geographic restrictions (though **no mention was made of rural vs. urban settings**). Inpatient mental health workers often felt that it was inappropriate and often counter-therapeutic to delve into their clients' histories. This reveals (1) the prevailing belief that trauma must be treated separated from SMI; (2) workers' pragmatic recognition that without specific programs and supports in place for women, it is not possible to begin providing trauma histories (page 20); and (3) workers' fear, misunderstanding, and lack of training. There is a **need for cross-training between sectors and specialized programs (for Aboriginal women, refugees, recent immigrants)**.

Moses, J.D. et al. (2003). Creating Trauma Services for Women with Co-Occurring Disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse, and Mental Health Disorders who have Histories of Violence Study. WCDVS (Women, Co-Occurring Disorders & Violence Study). <http://mentalhealth.samhsa.gov/nctic/publications.asp#women>

Based on research conducted by the Women, Co-Occurring Disorders and Violence Study (WCDVS) over five years across the United States, this report recognizes the impact of trauma on women's lives and calls for trauma-specific and trauma-informed services for women with co-occurring disorders. Challenges to developing these services were philosophical differences, resistance at the service level, resistance at the administrative level, limited resources, maintaining consistent participation in trauma groups, staff turnover, and the feeling that change is difficult (see detailed account above).

Poole, N. (2006). *Doing it all: Developing integrated support for women experiencing mental health, trauma-related and substance use problems.*

Centres of Excellence for Women's Health Research, Bulletin 5(1): 21-22.
<http://www.cewh-cesf.ca/en/publications/RB/v5n1/toc.shtml>

Included in the Spring 2006 Research Bulletin from the CEWH on Mental Health and Addictions in Women, this 2-page article covers the findings from a one-day public session called "Doing it all" which brought together 9 BC women-serving agencies who have delivered or are delivering integrated services for women dealing with mental health, addictions, and abuse. This article recognizes that there is growing recognition for the need for integrated services (influenced by programming developed in the US), and lists some of the **challenges in providing these services: recruitment, building community, and lack of stable funding.**

Sutherns, Rebecca, Marilou McPhedron, and Margaret Haworth-Brockman. *Rural, Remote, and Northern Women's Health: Policy and Research Directions Final Summary Report*. Centres of Excellence for Women's Health.
<http://www.pwhce.ca/ruralAndRemote.htm>

Included in the report is an excellent literature review and thematic bibliography based on literature that discusses the themes of "health," "women," and "rural." Thematic areas of focus in the literature review include: Aboriginal Women and Mental Health and Healing (page 90); Aboriginal Women and Sexual Abuse (page 92); Abuse and Violence (page 94); Mental Health (page 105); and Substance Abuse (page 114).

Tettero, May. 2008. *Reaching Out: The experiences of abused women in Grey Bruce*. Men's Program (Grey/Bruce) and Women's House. Full report available at mensprogram@bmts.com.

This two-year study of partners of abusive men participating in the Grey-Bruce Partner Abuse Response program (Men's Program) provides qualitative and quantitative data on rural women's experiences with abuse, service providers, and their help-seeking behaviours. Almost all women interviewed spoke about mental health and/or addictions concerns, whether their own or in reference to their partner (p. 23). Of particular interest to research on concurrent issues and rural women is Tettero's Research Supplement on woman abuse in rural areas (pp. 39-50). Her review of relevant research indicates that although Statistics Canada reports no differences in rates of spousal violence between rural and urban areas (Statistics Canada, 2005), significant differences do exist in terms of women's experiences of violence. Tettero's data suggest that women in rural areas experience more physical abuse and confirms that weapons form a part of domestic violence more often for rural women (p. 45).

In her literature review, Tettero draws largely on the research of T.K. Logan et al (2003 and 2004) and Susan Lewis (2001) in the United States as well as Kierryn Davis in Australia (2001). Similar to findings in the literature, Tettero identified **(1) lack of anonymity; (2) social and physical isolation; (3) stigma and shame; (4) poverty; (5) emphasis on traditional roles; (6) fear; and (7) inconsistent service provision as key barriers** hindering rural women's likelihood in seeking help.

Whyte, Jane Melville and Joanne Havelock. (2007). *Rural and Remote Women and the Kirby-Keon Report on Mental Health: A Preliminary Gender-Place Analysis*. Centres of Excellence for Women's Health. Available Online at www.pwhce.ca.

In response to the Kirby-Keon Report on Mental Health, Mental Illness, and Addictions, *Out of the Shadows at Last*, the authors use a **gender-place-culture analysis to add to and critique Kirby-Keon's recommendations by emphasizing the experience of rural women and mental health services**, as well as identifying experiences of abuse and family violence as critical factors in addressing and preventing mental health problems. The report also highlights the culturally specific needs of First Nations women, though the authors state that more research is needed in this area.

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Appendix 3 Gap Analysis

Issue: Identification Women and providers struggle to identify and respond to the complexity of what is happening in women's lives.

Present State	Gaps/Issues	Strategies	Desired Future
<p>Women struggle to identify their issues because of stigma, lack of information,</p> <p>Issue identification impacted by service mandates, staff expertise, training and comfort levels.</p> <p>The service door the woman walks in is the lens that defines her problem. Link between mental health, addiction, abuse not identified.</p> <p>No common screening, intake, assessment tools across sectors</p> <p>Current abuse issues usually identified but may not be linked to treatment response</p> <p>Past abuse issues often not identified (historical child sexual abuse, witnessing abuse, child abuse, multiple traumas)</p> <p>Early identification not common. - issue identification often a result of a crisis.</p> <p>Attitudes, systemic issues, family dynamics, roles, community (i.e. Mennonite) impede identification</p> <p>Complexity of presenting issues make identification of concurrent issues difficult (experience, knowledge, attitudes of providers)</p> <p>Issues are identified but not dealt with or women are not connected to supports</p>	<p>Comprehensive understanding and approach to women with concurrent issues</p> <p>Common screening and assessment processes across sectors</p> <p>Information for women</p> <p>Education and training on trauma and link to mental health and substance abuse</p> <p>Some providers not in the service loop at all (doctors, primary care)</p> <p>Early identification of concurrent issues</p>	<p>A process for understanding everything – an assessment that integrates issues for the woman (name issues, find voice, build self esteem and maintaining hope).</p> <p>Within services and across the system build relationships with women that look at her whole picture and integrated approach.</p> <p>A system approach – that integrates service delivery around some common goals</p> <p>Information on concurrent issues available for women</p> <p>Joint training on identification and response to concurrent issues.</p> <p>Include primary health care providers in coordinated response</p>	<p>Providers take time to get the whole picture and work with women to see her whole situation</p> <p>Focus is not on identification of one primary issue, or diagnosis, but on how to best address inter relating issues.</p> <p>Broad approach to issue identification that is not driven by service mandate</p> <p>All providers educated and competent on concurrent issues</p> <p>Central places for broad information and support for women. Women's Drop In</p> <p>Model</p> <p>Directory of services available to providers and women</p> <p>Common screening and assessment tools across sectors that support coordinated response</p> <p>Family doctors identify issues</p> <p>Women and providers have access to information about concurrent issues, identification of issues and community supports</p> <p>Proactive response to issues when they are identified</p>

Issue: Access There are many barriers to services and supports.

Present State	Gaps/Issues	Strategies	Desired Future
<p>Information about issues and services needs to be more available to women</p> <p>Abusers interfere with women accessing help</p> <p>No family doctor</p> <p>No access to psychiatrist</p> <p>Long wait for services, especially children's services, counselling services, out of town residential services</p> <p>No local residential treatment services for women with substance abuse issues. Women must leave the area for help.</p> <p>VAW rules and procedures not a good fit for women with concurrent issues</p> <p>Service hours and models don't work for working women</p> <p>Rural barriers: isolation, transportation, childcare,</p> <p>Financial barriers: poverty, lack of housing, cost of transportation, childcare, private counselling, working women don't qualify for assistance</p> <p>Low levels of trust impede access</p> <p>Not knowing what the issue is makes it hard to know what service to use</p> <p>Stigma associated with all the issues impedes women's ability to reach out for service, or access available services</p>	<p>Helpful and accessible information for women on concurrent issues and community services</p> <p>Protection from her abuser</p> <p>Timely access to service</p> <p>Residential services for women that accommodate her unique needs.</p> <p>Transportation</p> <p>Childcare</p> <p>Funded counselling</p> <p>Basic needs (housing, food, safety) not met</p> <p>Stigma difficult to overcome</p>	<p>Develop information and public education tools to inform women and providers about concurrent issues, community resources.</p> <p>Sectors work together to address rural and financial barriers.</p> <p>Advocate for housing, living wages, social assistance rates that cover basics</p> <p>Community wide strategies to address stigma and change attitudes towards women with concurrent issues.</p>	<p>Women and providers have access to a wide range of information about concurrent issues and how to get help.</p> <p>VAW services are accessible for women with mental health and addiction issues.</p> <p>Coordinated community action is used to address practical barriers such as transportation. (Overcome defeatist attitude towards issues such as transportation)</p> <p>Adequate affordable housing, living wage, adequate levels of social assistance.</p> <p>Access to primary health care and psychiatric services is assured.</p> <p>Services consider transportation and childcare needs of women in service planning</p> <p>Local residential services for women</p> <p>Service models and hours work for working women.</p> <p>Providers and women work together to address stigma. Lower levels of stigma and more informed public.</p> <p>Implement system wide checks and balances to limit the opportunities for abusers to manipulate the system and control victims.</p>

Issue: Service Response The service response is fragmented and confusing for women

Present State	Gaps/Issues	Strategies	Desired Future
<p>High level of referral activity between sectors when abuse, mental health, addiction issues identified. Women sent from service to service</p> <p>Providers generally aware of community resources, except family doctors.</p> <p>Lack of culturally appropriate services for Aboriginal women</p> <p>Providers need more training/competence to deal with concurrent issues.</p> <p>No help until woman is truly desperate (suicide attempt).</p> <p>Service response framed by type of service women access first or her 'primarily' service</p> <p>Medical model: too much medication, medications not monitored properly, side effects of medication undermine women's quality of life.</p> <p>Woman 'overloaded' with multiple interventions, people, and organizations.</p> <p>Providers and women search is for a 'primary issue' Tendency to look for quick fix or simple solutions</p> <p>Belief that there is a proper 'order' or 'sequence' for treatment/intervention that does not fit woman's needs or reality</p> <p>Lack of long term support/service plan over many years as woman deals with complex issues and life situations</p> <p>Service response often does not include supports for children, support for women with parenting issues.</p> <p>Women's mental health and addiction issues used against her within justice and child protection systems</p>	<p>Proactive response to help seeking</p> <p>Services that fit her unique needs</p> <p>Comprehensive approach</p> <p>Knowledgeable and monitored use of medications</p> <p>Coordinated service delivery</p> <p>Long term approach</p> <p>Vulnerable women lose within justice and child protection systems</p>	<p>Start with GBVPCC – train people at the table to provide system wide response, skill building, impact of trauma, counselling approach.</p> <p>Use existing Community Protocol for case management.</p> <p>Plan for building on plans and capacity building with Mental Health Addictions Concurrent Issues group</p> <p>Need a plan for involving physicians and psychiatrists – critical. Look at the Family Health Teams – start there as an opportunity.</p> <p>Contact In patient mental health.</p> <p>Provide supports for women, children, and on parenting.</p> <p>Look at ways of providing integrated services in one place.</p>	<p>Proactive response when women need it, not waiting for a crisis</p> <p>One stop approach (no door is the wrong door) where all partners provide information about abuse, addiction, mental health, and community supports)</p> <p>All places of help provide support and follow up and not just a referral</p> <p>Services provided in a non institutional setting that is personal, flexible, accessible and comprehensive</p> <p>Focus is on understanding impact of trauma, skill training, communication, self-care, social recreation, identifying and building strengths and supports.</p> <p>Counselling approach: listening, careful pacing, thorough assessment, education, systemic analysis, honesty, and warmth.</p> <p>Counselling for historic abuse, sexual abuse</p> <p>Integrated service response – services available in one place with a broad span of support (information, counselling, legal, children, etc.)</p>

Issue: Mandates and Philosophies There are conflicting or opposing mandates and philosophies between sectors and services that confuse women, limit services, and make a coordinated approach challenging

Present State	Gaps/Issues	Strategies	Desired Future
<p>Services are restricted by mandates</p> <p>Competitive stance (funding, service provision, optics) Hierarchy evident (resources, credibility, need for services)</p> <p>Unhelpful attitudes, stigma attached to services, between services</p> <p>Philosophy differs when consumers are part of staff. ('professional' and 'experiential')</p> <p>Agency/sector philosophies not understood, not known, not shared, between and within sectors</p> <p>Philosophies not always reflected in service delivery/practice</p> <p>Common areas of philosophy not known, not explored between agencies.</p> <p>No common 'philosophy of care' between sectors</p>	<p>Understanding of sector philosophies and mandates</p> <p>Mapping of common areas</p> <p>Identification of shared ground to support coordinated work</p> <p>Articulated mutual philosophy of care</p> <p>Strategies to address mandate barriers for women</p>	<p>Coordinated approaches – all sectors to address current policy and legislative issues.</p> <p>Training and information sharing to build a common 'philosophy of care' across sectors</p> <p>Include women (consumers) in development of philosophy of care and as advisors on service coordination.</p> <p>Implement integrated services where possible.</p>	<p>Goal is not for services to be homogeneous, but to work well within diverse philosophies</p> <p>Inclusive and partnership approach</p> <p>No closed doors, no wrong doors for women. Whatever a woman brings is right and we start there.</p> <p>Women are partners in the work</p> <p>Systems adapt to the woman's reality</p> <p>Justice and Child protection system work for women.</p> <p>All services address systemic inequalities facing women and promote equality and equal access for women.</p>

Issue: Service Coordination and Integration Sectors and services need to work together in a coordinated way and look at integrated service provision

Present State	Gaps/Issues	Strategies	Desired Future
<p>No shared vision of coordination or integration shared across sectors or within sectors</p> <p>Where coordination exists it is highly valued by women</p> <p>Services are client centred, but the system is not</p> <p>Service coordination attempted, notion of circle of care evident, but women report it is not working for them</p> <p>Coordination most effective at referral level. Follow up lacking to connect women to service, case management not happening, no longer term coordinated follow up</p> <p>Critical gaps in system: resources, (family doctors, psychiatrists, treatment options, training)</p> <p>Coordination impacted by rural realities (cost of services, distance, transportation, lack of services, communication issues, overworked and stretched social services, need to travel out of the area for services, high levels of poverty, substance abuse, lack of housing, farm crisis) information, Private counsellors not formally part of service network</p> <p>Coordination depends on the worker's expertise, knowledge, awareness and engagement, no formal structures in place to ensure coordination takes place.</p>	<p>Information sharing across sectors</p> <p>Model for integrated services</p> <p>Common tools</p> <p>Shared vision that supports collaborative approach</p> <p>Case management system</p> <p>Intersector Communication</p> <p>Intersector training and relationship building to support collaborative approach</p> <p>Partnership approach</p> <p>Protocols and agreements to support service collaboration.</p>	<p>Develop a Case Management model that prevents agency overload for women</p> <p>Develop and implement a common screening and assessment process that directs her to the best place of support</p> <p>Ensure there is a person who provides support for the woman as she moves from service to service (anchor, bridge)</p> <p>Joint training and protocol development on working together.</p> <p>Develop protocols and agreements (or expand existing structures) to define and support a coordinated community response.</p>	<p>Shared vision of care and coordinated model for service provision</p> <p>Common screening and assessment used in all sectors that is built upon, not disregarded</p> <p>Primary health care and psychiatrists are part of coordinated response</p> <p>Case management system is used across the system.</p> <p>Presence of an 'anchor' for the woman (person or agency at the centre over the longer term, provides bridges for women)</p> <p>Service coordination helps women make connection between trauma, mental health, and addictions earlier. Less service duplication, and fewer gaps for the women.</p> <p>Integrated model of service for rural area (services are available at one location, joint staffing,</p>

Issue: Training Service providers identified the need for training to improve the service response and service collaboration

Present State	Gaps/Issues	Strategies	Desired Future
<p>Providers want training on connection between abuse/trauma and mental health/addiction issues and dealing with concurrent issues</p> <p>Training needed for medical profession</p> <p>Training requested on integrated service models</p>	<p>Intersector training on concurrent issues, impact of trauma, service response, collaboration.</p> <p>Training and information for primary care providers</p> <p>Training on models of integrated service delivery for rural communities</p>	<p>Organize and implement intersector training on training issues identified by providers and consumers</p> <p>Include women in the delivery of training.</p> <p>Engage primary health care providers in joint training.</p>	<p>All Providers trained in integrated service delivery model, and their role</p> <p>All providers trained on dealing concurrent issues and impact of trauma on mental health and addiction</p> <p>Police, justice and child protection systems trained on impact of trauma and response to women with concurrent issues</p> <p>Sectors all understand roles, mandate, work of others, and how to build on this</p> <p>Primary Care (Physicians, nurses, etc.) trained in identification of issues, community resources, use of medication, their role in integrated response</p>

Issue: Resources There are resource and capacity issues that must be addressed.

Present State	Gaps/Issues	Strategies	Desired Future
<p>Limited resources and services for Aboriginal women</p> <p>Public resources focused on serious mental health issues where there is a diagnosis of a major mental illness. Services needed for mild-moderate issues.</p> <p>Private counselling services not affordable.</p> <p>Wait lists for services Underserved area for family doctors, psychiatrists.</p> <p>No resources for the development of an integrated service model or to address service gaps</p>	<p>Services for Aboriginal women</p> <p>Services for women with mild-moderate mental health issues</p> <p>Resources for intersector training</p> <p>Resources to develop integrated model for rural communities.</p>	<p>Work with First Nations services and implement culturally appropriate services.</p> <p>Develop models for integrated service delivery that works in our rural community.</p> <p>Advocate for new services for women with mild-moderate mental health issues that are trauma informed.</p>	<p>Resources for Aboriginal women</p> <p>Continuum of counselling services for women with mild, moderate and serious mental health and/or addiction issues who are dealing with current and or past abuse/trauma</p> <p>Family doctors and psychiatrists available</p> <p>Integrated service model in place</p>

Appendix 4 Service Provider Survey Tool

1. Rural Strategies for Women with Abuse, Mental Health and Addiction Issues

Thank you for taking the time to fill out this survey and for your important work in this community!

The Grey Bruce Domestic Violence Prevention Committee is carrying out a project to develop rural strategies for women in Grey Bruce with abuse, mental health and/or addiction issues. This research and community development project is guided by a Community Advisory Committee made up of providers and consumers of mental health, addiction and violence against women services. The project is funded by the Victim's Services Secretariat of the Ontario Ministry of the Attorney General.

The Goals of the Project are:

1. To identify gaps in service for women with abuse, mental health and/or abuse issues.
2. To hear from women how to better meet their service needs.
3. To develop community strategies to improve service delivery through coordination and training.
4. To develop community strategies to address service gaps that compromise the health and safety of women with multiple needs.

This survey is for service providers in the addictions, mental health and violence against women sectors. It is part of an information gathering phase that also includes focus groups with women in November and December and a review of literature.

In early 2008 we will bring together service providers and consumers to review the information gathered and to develop Community Strategies to improve service delivery. In the spring of 2008 there will be a training workshop for service providers from the three sectors and a Final Report on the project will be completed.

If you are interested in attending the Community Strategies workshop or the Training Workshop, or if you would like an electronic copy of the Final Report, please let us know.

In terms of confidentiality, the identity or any identifying information of individual survey participants will not be disclosed. Your response to this electronic survey is confidential, password protected, and can only be accessed by the project coordinator. Collated data from the survey will be used to develop strategies and plans for the project.

If you have any questions, please contact:

Colleen Purdon,
Project Coordinator
cpurdon@bmts.com
(519) 376-7145

You can find more information about the GBDVCC and the project at www.endabusenow.ca

If you know of others who you think would like to respond to this survey, please forward it to them.

Thank you and all the best for the holiday season and the new year!

Colleen Purdon,
Grey Bruce Domestic Violence Coordinating Committee

2. Your Perspective

It's important to know which sector and perspective you represent so we can develop sector specific and broad community strategies from the project data.

*** 1. Please let us know the primary focus of your work**

- Mental Health Service Violence Against Women Service
 Substance Abuse Service Other

Please Specify

*** 2. What is your gender?**

- Female Male Other

3. What position do you have in your organization?

- Senior Manager Front Line Worker
 Supervisor Other

Please Describe

3. Screening and Intake

1. When you do an intake do you routinely ask women questions about:

	Yes	No	Don't Know	Does not Apply
Current and/or Historical Abuse/Trauma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental Health Issues/Concerns	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance Abuse Issues/Concerns	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

2. Please check the issues you routinely ask women about as part of the assessment process at your organization (check as many as apply)

- | | | |
|-------------------------------------------------|---------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> emotional abuse | <input type="checkbox"/> childhood abuse | <input type="checkbox"/> substance abuse treatment |
| <input type="checkbox"/> physical abuse | <input type="checkbox"/> mental health concerns | <input type="checkbox"/> other |
| <input type="checkbox"/> sexual abuse | <input type="checkbox"/> mental health treatment | |
| <input type="checkbox"/> childhood sexual abuse | <input type="checkbox"/> substance abuse concerns | |

Comment

3. Does your agency have a procedure or protocol that requires you to screen for abuse/trauma issues?

- Yes
 No
 Don't Know

Comment

4. When do you believe is the best time to talk to women about abuse/trauma? (answer as many as apply)

- | | | | | | |
|------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------|--------------------------------|
| <input type="checkbox"/> When the woman brings it up | <input type="checkbox"/> At initial Screening interview | <input type="checkbox"/> As part of the Assessment | <input type="checkbox"/> During a counselling session | <input type="checkbox"/> When the worker suspects abuse | <input type="checkbox"/> Other |
|------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------|--------------------------------|

Comment

5. How would you rate your current comfort level asking questions about abuse/trauma, mental health issues, substance abuse issues?

	uncomfortable	somewhat comfortable	comfortable	very comfortable
Abuse/Trauma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental Health Issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance Abuse Issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

4. Response to Disclosures

We would like to know how you respond when a woman speaks about her abuse/trauma, addiction and/or mental health issues.

1. When you encounter a woman who is dealing with abuse/trauma, mental health issues, substance abuse issues what do you usually do?

- Refer her to an agency that deals with the specific issue
 Refer her to someone in your own agency who specializes in that issue
 Deal with it myself
 No immediate action - wait to see if it comes up again
 Other

Comment

2. How do you usually address safety issues when a woman discloses current physical, emotional and/or sexual abuse?

- Complete Safety Planning with woman using agency tool
 Refer the woman to a local VAW organization for safety planning
 Consult with VAW and then complete Safety Planning with woman
 Consult with CAS
 Other

Comment

3. What would stop you from talking to a woman about her abuse/trauma, mental health issues, and/or substance abuse issues. (answer as many as apply)

- Don't have the training I need
 Don't have the time
 Concern about how to handle a disclosure
 Concern about making the woman uncomfortable
 The woman does not appear to have this problem
 Not the mandate of our service
 Other
 Not Applicable

Comment

4. On the scale below how would you rate your competence level in each of the following situations:

	poor	fair	good	excellent
Dealing with abuse/trauma issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dealing with Mental Health Issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dealing with Substance Abuse Issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Working with abused women who also have mental health and/or substance abuse issues.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

5. Community Resources

Please let us know how you use community resources and if there are additional resources that we need.

1. On the scale below how would you rate your knowledge of community resources for women with abuse, mental health and addiction issues?

	poor	fair	good	excellent
Violence Against Women Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental Health Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance Abuse Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Housing Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Income Support Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Legal Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

2. When you refer women with concurrent abuse/addiction/mental health issues, are the services they need available?

Never
 Some of the time
 Most of the time
 All of the time
 Not Applicable

Comment

3. How would you rate the significance of the barriers listed below for women with concurrent issues who are seeking help? (please rate each of the barriers listed)

	not significant	somewhat significant	significant	very significant
poverty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
lack of information about services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
lack of transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
women don't know where to go first	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
wait lists for services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
women don't trust agencies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
inflexible service hours	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
location of services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

4. Women with concurrent abuse, mental health and addiction issues report that they have trouble getting the kind of help they need. Why do you think this is being reported? (please rate each of the responses below)

	strongly disagree	disagree	agree	strongly agree
Services for women with concurrent issues need to be coordinated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Workers in different sectors need to share a common understanding of the issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Workers need more training to help women with concurrent issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There are barriers because of different service philosophies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There are barriers because of different service mandates	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

5. How important is it for women with concurrent abuse, mental health and addiction issues to have women only programming?

- Not Important Somewhat Important Important Very Important

Comment

6. What new services or supports do you think are most needed for women dealing with addiction, mental health and abuse issues concurrently?

6. Community Collaboration

This section looks at coordination, collaboration and rural strategies to improve services for women with concurrent issues.

1. How would you rate the current level of collaboration between the mental health, addictions and violence against women sectors?

Poor
 Fair
 Good
 Excellent

Why?

2. If you have worked with women with concurrent issues who are also involved with the justice system (family court, criminal court) please answer this question.

How is a woman's recovery (counselling, treatment, etc.) viewed by the court system?

3. If you you have worked with women with concurrent issues who are also involved with the Child Welfare system please answer this question.

How is a woman's recovery (counselling, treatment, etc.) viewed by the CAS system?

4. On the scale below, rate what you believe would improve service collaboration for women with concurrent issues? (please rate each line)

	not important	somewhat important	important	very important
Interagency training on integrated approaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Formal case management protocols	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sharing information and expertise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Training on trauma and link to mental health and addictions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Common Screening and Assessment Practices	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Joint strategies to address service gaps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

5. What are some examples of best practices in coordination and collaboration between the mental health, addiction and violence against women sectors?

7. Thank You!!

1. Do you have any other comments for us?

2. Thanks for completing this survey!

If you are interested in attending the Community Strategies Workshop in the new year to develop community strategies from survey and focus groups findings please contact:

**Colleen Purdon
Project Coordinator
(519) 376-7145
cpurdon@bmts.com**

Your participation at the Strategies Workshop would be most welcome!

A Final Report on the research findings, recommendations and training priorities will be available in the spring 2008. The report will be available on the GBDVCC website www.endabusenow.ca or you can provide your contact information below and we will send you an electronic copy.

Thanks Again!

Appendix 5 Focus Group Information Package

Rural Strategies for Women With Abuse, Mental Health and Addiction Issues

**A Research and Community Development Project
of the Grey Bruce Violence Prevention Coordinating Committee
July 2007- June 2008**

Consent Form for Focus Group and Interview Participants

About the Project

Women living in rural areas with experiences of past or current physical, emotional, and/or sexual abuse and who also deal with mental health and/or addiction issues face many challenges. The Rural Strategies for Women project aims to improve our community response to abused women with complex needs in our rural community. A Community Advisory Committee made up of service providers and women who have used mental health, addiction and abuse services in the community guides the project. The Grey Bruce Violence Prevention Coordinating Committee received funding from the Victims Services Secretariat of the Ontario Ministry of the Attorney General to carry out this project. Colleen Purdon and May Tettero are working together to carry out this project.

Confidentiality

We are committed to keeping what you tell us confidential.

- With your consent we will tape the focus group/interview, and we will also take notes. If there is a tape, a transcript (a word-for-word written version of what you say) will be made as soon as possible and then the tape will be destroyed. Your name will not appear on the tape, on the transcript or on any notes that we make. The only place that your name will appear is your signature at the bottom of this consent form. Your signature on this form (that is, your consent) will not be matched up with the interview tape or transcript in any way.
- Only the person who transcribes the tape of the focus group/ interview will have access to the tape recording. Members of the Advisory committee will not have access to the transcripts.
- In any report or paper written about the research your name will not appear. We will also make sure that no other identifying information about you is included.

- If you say something to the facilitator during the focus group/interview and you decide that you do not want that included it will be removed.
- No one will be told that you have been interviewed.

There is, however, one exception to confidentiality. If the interviewer receives information that suggests that a child is being abused, then the interviewer is required by law to report this to the Children's Aid Society.

What will be done with it the information?

The researchers who conduct the focus groups and interviews will use the information to prepare a summary report of findings that will be discussed at a workshop of women who use services and service providers from mental health, addictions and abuse agencies. If you are interested in attending this workshop, please let us know. The results of the workshop will be used to develop a training session for service users and to prepare a Final Project Report. The report will recommend community strategies to improve service delivery through service coordination and training, and strategies to address service gaps that compromise the health and safety of women with complex needs. If you would like a copy of the final report, please let us know.

Your participation in this project is completely voluntary. If you do decide to participate you can change your mind at any time and withdraw. Also, during the focus group or interview, you can decide to end the session at any time; you can also choose not to answer any question; or decide that something you have said you don't want to have included after all.

Support

We will provide each participant with a small honorarium to help cover their out of pocket expenses.

If you have any questions about this project you can contact the Project Coordinator Colleen Purdon by calling her at (519) 376-7145 or May Tettero at (519) 369-2026

Consent to participate

I consent to participate in the research project described on this form. In signing this form I acknowledge that I have read this letter (or have had it read to me) and that I have been given a copy of it.

Participant's Signature

Date

Consent to the taping of the focus group or interview

I agree to the tape recording of the focus group/interview. The tapes will be transcribed as quickly as possible and thereafter destroyed. My name will not be recorded on the tape or on the transcript.

Participant's Signature

Date

Rural Strategies for Women with Abuse, Mental Health and Addictions Issues

Focus Group Guide

Facilitator Script

Thank you so much for being part of this focus group.

The Grey Bruce Domestic Violence Coordinating Committee is carrying out this research and community development project to develop rural strategies for women with mental health, addiction and abuse issues. We are consulting with women and with service providers to identify gaps in service for women, to hear from women on how to better meet their needs and to develop community strategies to improve the way services are provided. This focus group is the first phase of the project where we are gathering information about your experiences with services and your recommendations on what would improve services for women who are dealing with many difficult issues. We will complete a summary from your input and from survey responses from service providers, then hold a workshop with women who have used services and service providers to develop recommendations to improve services, and to plan for a training session for providers in the spring. We will also prepare a final report on the project with recommendations that will be available early in the summer. If you would like to attend the workshop, or would like a copy of the final report, please let us know at the end of this focus group.

Before we begin, we'd like to review with you some of the highlights of the consent form you signed. It is completely your decision to answer or not answer any of the questions we ask. If you are not comfortable answering a question, just pass. You are free to leave the focus group at any time, but please let us know if you are not coming back.

We would like to tape this focus group, and one of us will also take hand written notes. After the focus group we will make a transcript of the discussion. The transcript will not include any names or identifying information. Taping is the best way to get all of your information in an accurate way, but if anyone is uncomfortable with this, then we can do without it as well. Is everyone in agreement with the taping?

The information that you share is confidential, and we ask each person here today to keep it confidential. Your name, or identifying information that comes up from the focus group, will not appear in any report. If you decide something you have told us during the focus group shouldn't be included after all, we will take that information out of the transcripts. The only thing that couldn't be changed is that if you told us that a child was currently being abused—we would need to report that.

Before we begin, do you have any questions at all about the project? About the focus group? Anything else?

Focus Group Questions

Introductions:

Go around the circle and everyone says their first name and a few words about their interest in the focus group.

A. Reaching Out for Help – Mapping Exercise

1. Women dealing with abuse, mental health and addictions issues have many different paths to services and supports. We would like you to take a few minutes to draw a map of the way you have used services and supports.

Pass out paper and markers.

Each woman draws a circle in the middle of the page that represents her. She then draws a line to the person or service that she first met because of mental health, addiction or abuse issues in her life, and marks this with the number 1. Then draw a line to the next service or person or place that she went to, and marks it with the number 2. She continues drawing lines until she has a map or picture of all of the different services and or people that have she has been involved with to deal with mental health, addiction and abuse issues to the present.

Discussion

How easy or difficult was it to get help?

- Were there things that stood in the way?

- Do you think living in a rural area had any impact on the way you reached out for help?

How did you know what service or support to go to first?

- What service did you go to first? Why?
- Was this the right choice for you? Why or Why Not?

When you look at your map, what comes to mind?

B. Experience of Service

1. We would like to hear a bit about your experiences with community services that you used because of mental health, substance abuse and abuse issues.

Probes

- What were you hoping for? What did you expect?
- How helpful was the response? What would have made it more helpful?
- To what extent did you feel understood and listened to by the worker/service?
- Did you feel like an active participant in your treatment/healing?
- Were your safety needs addressed?

2. What happened after your first contact with a community service?

Probes

- Did you get referred to other services?
- Did you go to other services? How helpful were they?
- Were there differences in the way different services understood your issues?
- How well did workers understand your “whole picture” and all of the issues you were dealing with?

C. Accessing Services

1. Were the services and supports you needed for your abuse, mental health and addiction issues available?

Probe

- Were they the ‘right’ kind of services for you? What did you need?
- Did you experience any barriers that made it hard to get to services, for example transportation, childcare, getting time off work, poverty, other?
- Was the location or times of services a problem
- Did an abusive partner interfere?

- Were services culturally appropriate? Did you experience racism?

2. What would make services more accessible?

Probe

- How do you think living in a rural area affects your ability to access services?
- What would make services easier to access in rural areas?

D. Connections and Coordination

1. What was your experience of service coordination?

Probes

- Did staff in different organizations know about one another and work together
 - If you were involved with legislated services like CAS, police or the courts, how well were they coordinated with other services you used?
 - Do you have any suggestions on how to improve coordination?
2. How did you experience connections with services and workers?

Probes

- Is it important for you to have a personal connection to a person or agency? Why or why not?
 - What do services need to do to have a good connection with women who are dealing with mental health, addiction and abuse issues? (female only groups, services? Integrated services?, etc.)
3. From this discussion today, what do you think is the most important way to improve services for women with mental health, addiction and abuse issues?

Thank you. If you would like a copy of the report, or would like to participate in the workshop with service providers, please leave your name.

Appendix 6 Interview Guide

Rural Strategies for Women with Abuse, Mental Health and Addictions Issues

Interview Guide

Thank you so much for agreeing to be interviewed. I really do appreciate it. Before we begin, I'd like to just review with you some of the highlights of the consent you have signed. You can decide to end the interview at any time; you can also choose not to answer a question, or decide that something you have told me shouldn't be included after all. The only thing that couldn't be changed is that if you told me that a child was currently being abused--I would need to report that.

Before we begin, do you have any questions at all about the project? About the interview? Anything else?

A. Reaching Out for Help

1. Women dealing with abuse, mental health and addictions issues have many reasons for getting help. Can you talk a bit about why you got help?

Probes

- Was there one specific issue or was it a combination of things?
- Did someone advise you or take you to get help?
- Were you in charge of getting help, or did it happen because of a crisis situation?
- When did you first get connected with services (abuse, mental health, addiction)? What year?

1. How easy or difficult was it to get help?

- Were there things that stood in the way, or made it more possible?
- Do you think living in a rural area had any impact on getting help?

2. How did you know what service or support to go to first?

Probes

- What service did you go to first? Why?

- Was this the right choice for you? Why or Why Not?

B. Experience of Service

1. We would like to hear a bit about your experiences with community services that you used because of mental health, substance abuse and abuse issues. Can you say a bit about your experience of services?

Probes

- What were you hoping for? What did you expect?
- What happened? How helpful was the response? What would have made it more helpful?
- To what extent did you feel understood and listened to by the worker/service?
- Were you asked about abuse (present or past) when you went for help with your mental health and/or addiction issues? Did the worker talk to you about safety or do a safety plan?
- If you came first in contact with a VAW organization, were you asked about mental health and addiction issues? Did your mental health or substance abuse issues have an impact on using VAW services?
- In general, how welcoming was your first contact with a service? Why?

2. What happened after your first contact with a community service?

Probes

- Did you get referred to other services?
- Did you go to other services? How helpful were they?
- Were there differences in the way different services understood your issues?
- How many different services have you used? How long have you used different services?
- How well did workers understand your “whole picture” and all of the issues you were dealing with?

C. Accessing Services

1. Were the services and supports you needed for your abuse, mental health and addiction issues available?

Probe

- Were they the ‘right’ kind of services for you?
- Did you experience any barriers that made it hard to get to services, for example transportation, childcare, getting time off work, poverty, other?

- Was the location or times of services a problem
 - Did an abusive partner interfere?
 - Were services culturally appropriate? Did you experience racism?
2. What would make services more accessible?

What would make services more accessible in rural areas?

D. Connections and Coordination

1. What was your experience of service coordination?

Probes

- Did staff in different organizations know about one another and work together?
 - If you were involved with legislated services like CAS, police or the courts, how well were they coordinated with other services you used?
 - In general, how do you think services could work together better?
2. How did you experience connections with services and workers?

Probes

- How important is a personal connection to a person or agency for you? Why or why not?
 - Do you think it is important to have female workers or all female groups for women dealing with mental health, addictions and abuse issues? Why or why not?
 - Did workers help you make connections between your abuse, mental health and substance abuse issues? Would this be helpful or not?
3. In summary, what do you think is the best way to improve services for women with mental health, addiction and abuse issues?

Thank you. If you would like a copy of the report please leave us with your contact information.

Appendix 7 Mapping Women’s Experience Tool

**Rural Strategies for Women
with Abuse, Mental Health and
Addictions Issues**

Mapping Exercise

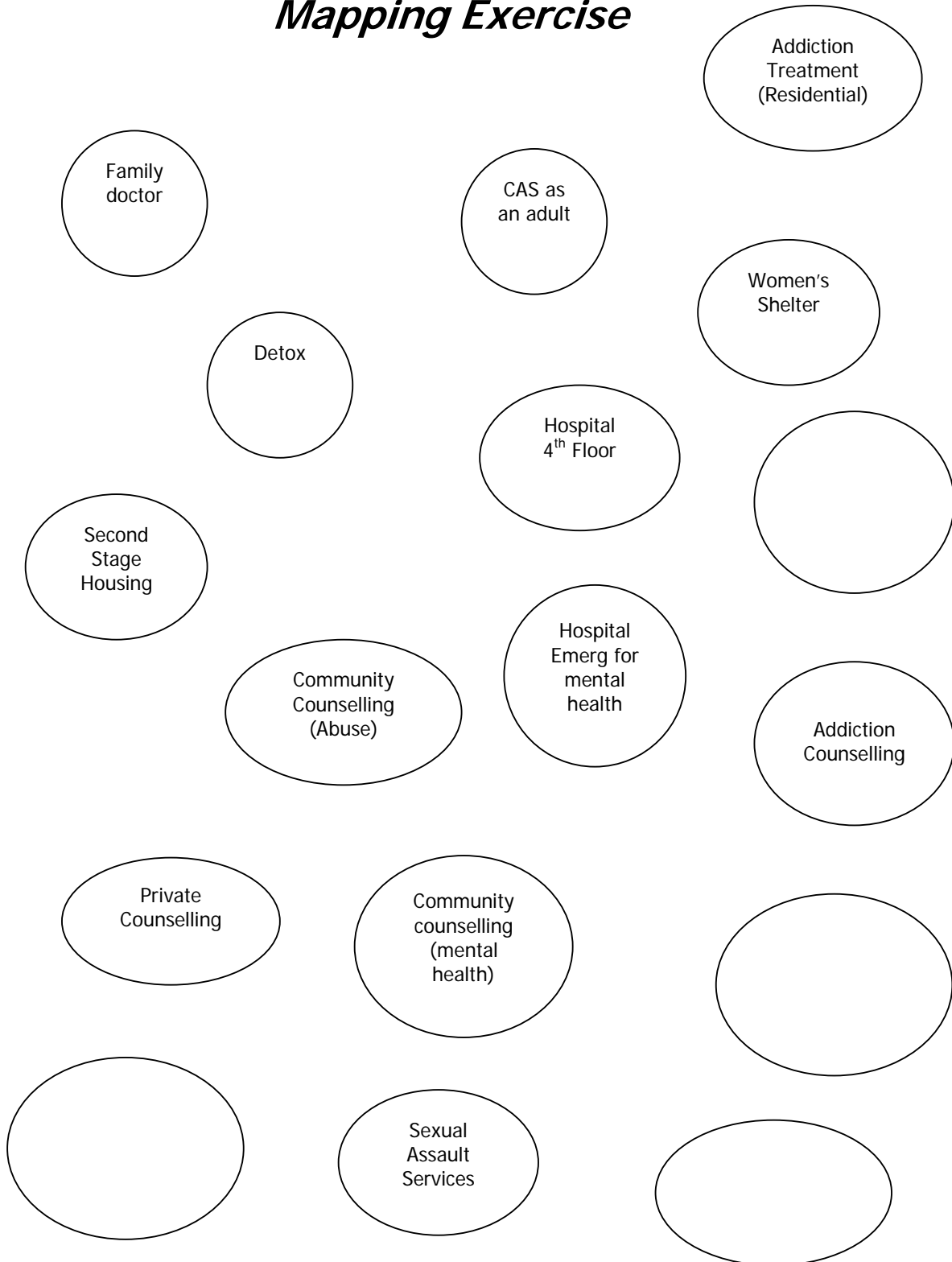
I have experienced.....

(Circle any of the issues listed in the three columns below that apply too you)

Mental Health	Addictions	Abuse/Trauma
Anxiety	Alcohol addiction	Witnessed abuse as a child
Chronic stress	Binge drinking	Child abuse/neglect
Post Partum Depression	Addiction to Prescribed Medications	Sexual abuse as a child
Panic attacks		Sexual abuse as teen/adult
Eating Disorder	Addiction to non prescription drug	Physical abuse by adult partner/husband
Depression	Gambling addiction	Emotional abuse by husband/partner
Phobia	Addicted partner/husband	Sexual abuse by partner/husband
Bi polar disorder	Addiction issues in family when I was a child	Traumatic accident
Suicide attempt	Addiction to multiple substances at same time	Traumatic loss of family member
Psychosis		Other (please describe)
Other (please describe)	Other (please describe)	

Rural Strategies for Women with Abuse, Mental Health and Addictions Issues

Mapping Exercise



Appendix 8 Community Strategies Workshop Agenda

**Rural Strategies for Women
With Abuse, Mental Health and
Addiction Issues**

Community Strategies Workshop

**Friday April 18th, 2008
9:30 – 2:30**

**St. Andrews Church, (Chapel downstairs)
265 2nd Avenue West. Owen Sound**

FACILITATOR AGENDA

9:30 Welcome – in the big circle
Introduce Ourselves

Overview of the project, why we are here today (Colleen)
Housekeeping (bathrooms, lunch, honorariums, safety) (Colleen)

Warm Up (May)

Summary of Findings on Issue Identification and Response
(May – women's input, Colleen - input from providers and literature)

Introduction of the World Café concept and process: each person is a facilitator and participant, respect and listening, participating, not censoring, creative process, random is good, outside the box is good, new ideas, finding commonalities in difference, doodle, valuing, etc. (Colleen)

10:30 World Café Opens – people go and get a drink, something to eat and find a place at one of five tables – looking for a place with diverse people.

The morning café will look at strategies to identify and respond to the issues

Discussion: (20 minutes)

Each person introduces himself or herself by saying why it is important for me to be at this strategies workshop

Question for the table: What would help me get of the box and move towards an understanding of the whole picture?

Each person writes down what was most important for him or her on bright paper before leaving. The person who stays writes down key points from the discussion.

Discussion (20 minutes) move to a new table group, one person stays.

Introductions

What stands in the way of a more holistic way of understanding these issues? What would it take to respond differently?

Each person writes down what was most important for him or her on bright paper before leaving. The person who stays writes down key points from the discussion.

11:30 Take Up from the Discussions – Strategies to identify and respond

12:00 Lunch (provided) Honorariums distributed

12:45 Summary of Findings on Working Together (May – women's input, Colleen input from providers and literature)

1:00 World Café Continues - Everyone moves to a new table Discussion: (20 minutes)

Introductions

What does working together look like? Who is included? How do we make it happen?

Each person writes down what was most important for him or her on bright paper before leaving. The person who stays writes down key points from the discussion.

Discussion: (20 minutes) move to a new table

Introductions

What are our priorities for change for our community and us?

Each person writes down what was most important for him or her on bright paper before leaving. The person who stays writes down key points from the discussion.

1:45 Summary: Community Strategies (in the big circle)

Each person writes down 5 priority strategies

Take up on the flip chart

Each person puts their stickers on the priorities that most important to them.

**2:15 Closing of World Café and Thanks
Go Around with Participants
Evaluations**

Other: **Collect all bright paper and table clothes input
Collect all notes from table note takers
Collect Flip Chart notes with stickers**

For more information about the workshop or project contact Colleen Purdon, cpurdon@bmts.com or (519) 376-7145

Appendix 9 No Wrong Door Workshop Agenda

“No Wrong Door”

A Workshop to Build Community Connections for Women with Mental Health, Addictions and Abuse Issues

Tuesday June 10, 2008 9:00 – 4:00

AGENDA

- 9:00 Introductions
- 9:30 Reaching Out to Abused Women with Concurrent Mental Health and Addiction Issues
Saundra-Lynn Coulter, Sarah Hilton and Susan Macphail, Women’s Mental Health & Addictions Research Coalition
- 10:30 Break
- 10:45 Service Principles, Role Play, Questions to consider
- 12:30 Lunch
- 1:15 Grey Bruce Rural Strategies Research Findings and Community Strategies
Colleen Purdon and May Tettero
- 2:00 Discussion: Are we ready to make change? What are the system and service and community issues and strategies that are most important to move on?
- 2:30 Break
- 2:45 Small Group Planning Discussions: What can we do with existing resources? What is needed to move forward (buy in? resources? training? Etc.) Who needs/wants to be involved in the next steps?
- 3:30 Summary of Plans for next steps
- 3:45 Closing and Evaluation

Endnotes

ⁱ Moses, J.D., Reed, B. G., Mazelis, R., & D'Ambrosio, B. (2003). *Creating Trauma Services for Women with Co-Occurring Disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse, and Mental Health Disorders who have Histories of Violence Study*. WCDVS (Women, Co-Occurring Disorders & Violence Study).

ⁱⁱ Purdon, Colleen and Tettero, May. 2004 and 2005. "The Grey Bruce Response to Domestic Violence Report Card 2004 and 2005"

ⁱⁱⁱ SAMHSA downloaded at http://mentalhealth.samhsa.gov/cre/ch1_scope.asp

^{iv} Centre for Addiction and Mental Health. About Mental Health and Addictions. Downloaded at http://www.camh.net/About_Addiction_Mental_Health/Drug_and_Addiction_Information/Addiction_Information_Guide/addiction_causes.html

^v Dennis, D et all, (1998) "What Do We Know About the Systems Integration and Homelessness?" Downloaded at <http://aspe.hhs.gov/ProgSys/homeless/symposium/toc.htm>

^{vi} Barnsley, Jan and Diana Ellis. 1992. "Research for Change: Participatory Action Research for Community Groups." The Women's Research Centre.

^{vii} Stringer, Ernest. 2007 *Action Research Third Edition*. Sage Publications

^{viii} Brown, Juanita and Isaacs, David and the World Café Community. 2005 "The World Café: Shaping Our Futures Through Conversations That Matter" Berrett-Koehler Publishers, Inc. San Francisco

^{ix} For extensive information on the impact of violence on children go to the website of the Centre for Research and Education on Violence Against Women and Children: <http://www.crvawc.ca>

^x Moses, J.D., Reed, B. G., Mazelis, R., & D'Ambrosio, B. (2003). *Creating Trauma Services for Women with Co-Occurring Disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse, and Mental Health Disorders who have Histories of Violence Study*. WCDVS (Women, Co-Occurring Disorders & Violence Study).